FIG. 1
(PRIOR ART)

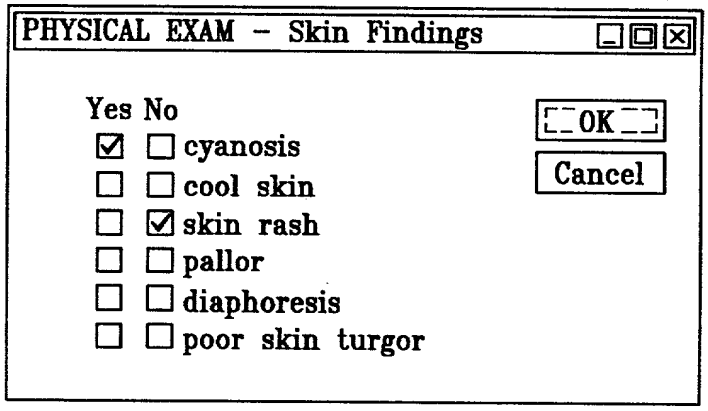

FIG. 2

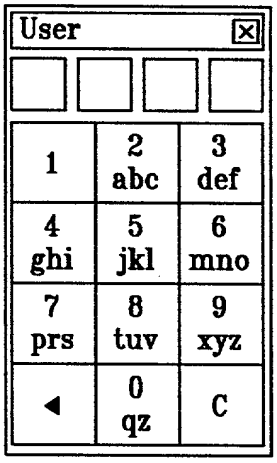

FIG. 3

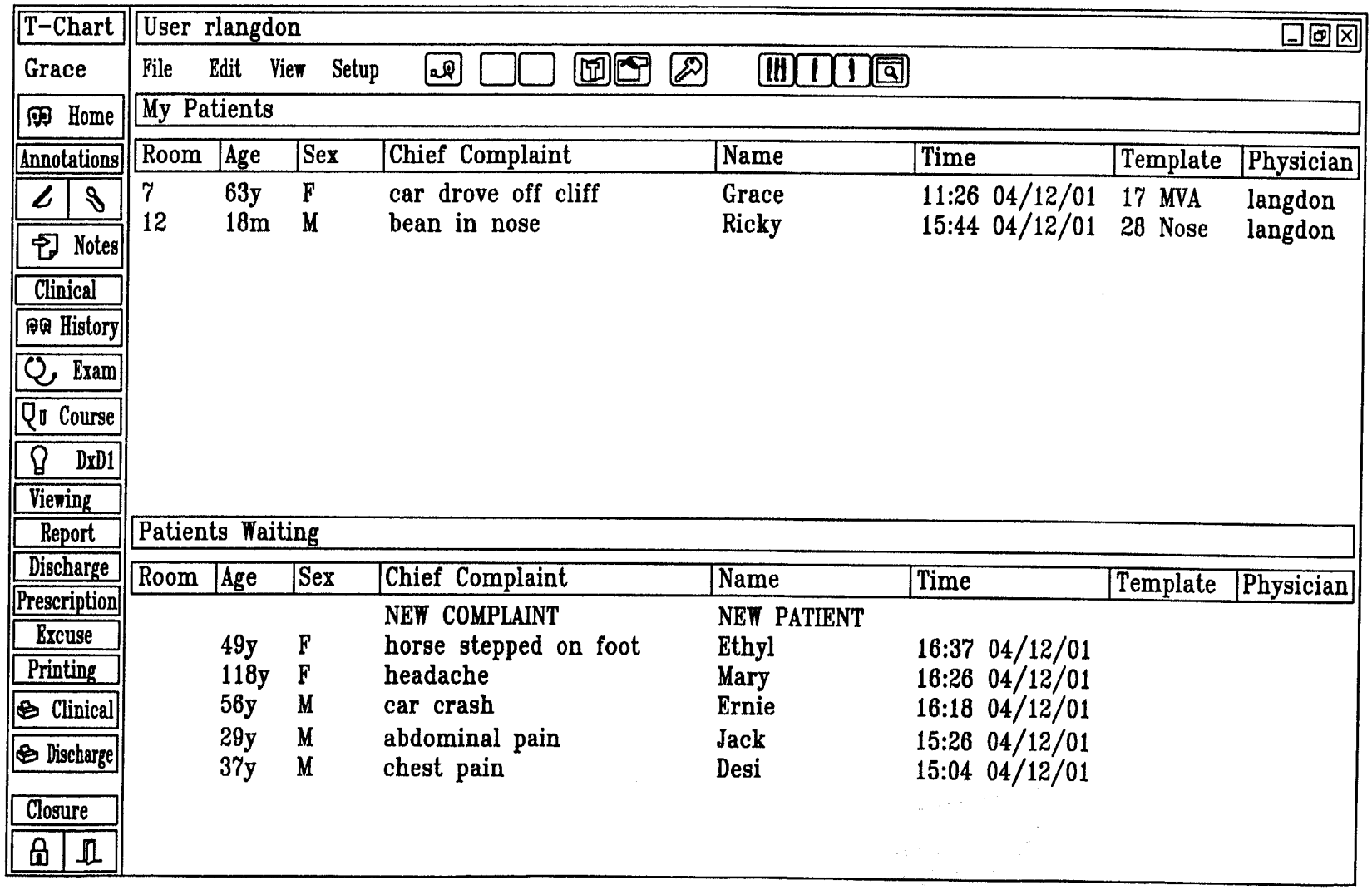

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FIG. 4

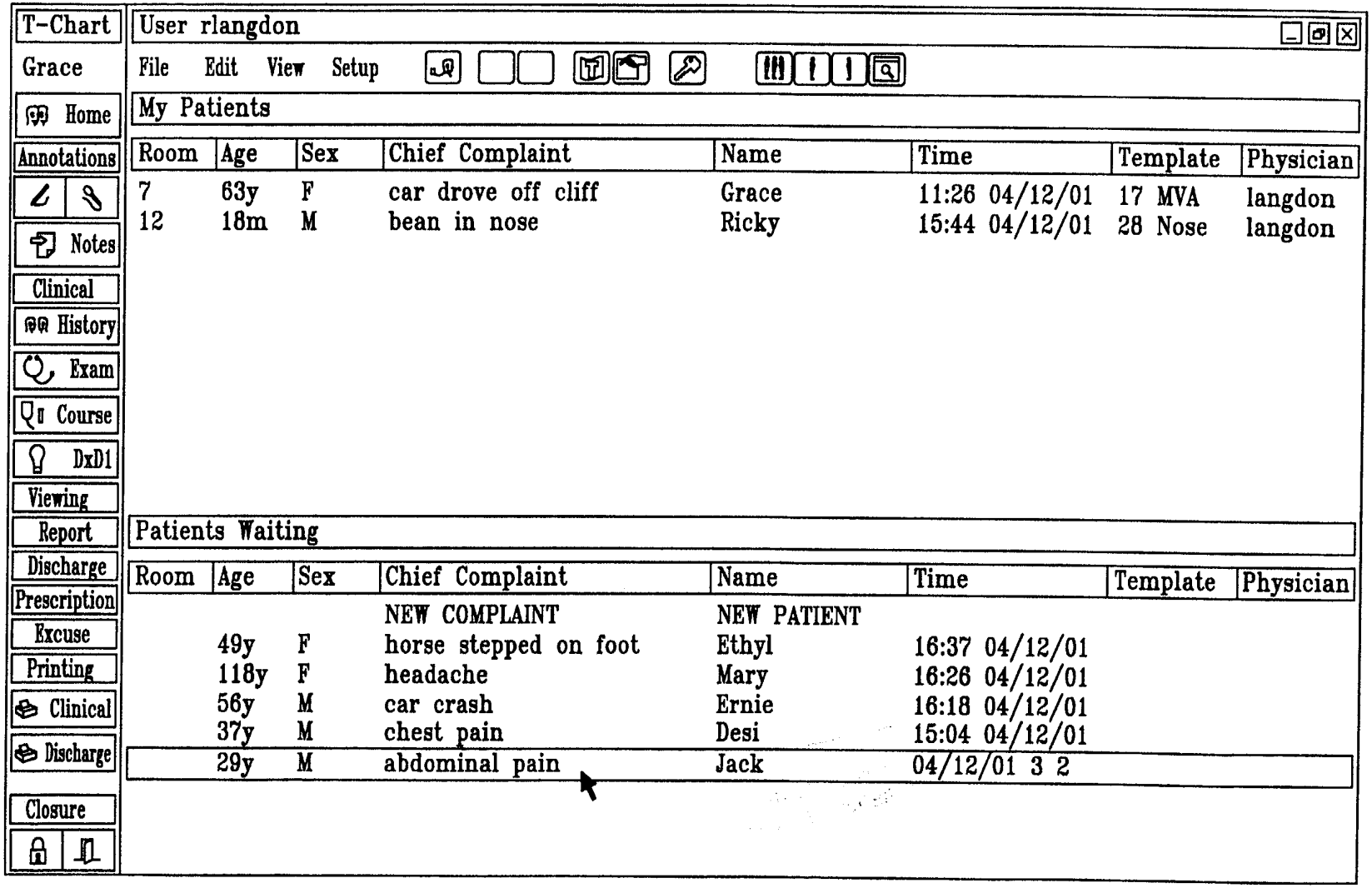
T-Chart
Grace
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
User rlangdon
File Edit View Setup
My Patients
Room Age Sex Chief Complaint Name Time Template Physician
7 63y F car drove off cliff Grace 11:26 04/12/01 17 MVA langdon
12 18m M bean in nose Ricky 15:44 04/12/01 28 Nose langdon
Patients Waiting
Room Age Sex Chief Complaint Name Time Template Physician
NEW COMPLAINT NEW PATIENT
49y F horse stepped on foot Ethyl 16:37 04/12/01
118y F headache Mary 16:26 04/12/01
56y M car crash Ernie 16:18 04/12/01
37y M chest pain Desi 15:04 04/12/01
29y M abdominal pain Jack 04/12/01 3 2

FIG. 5

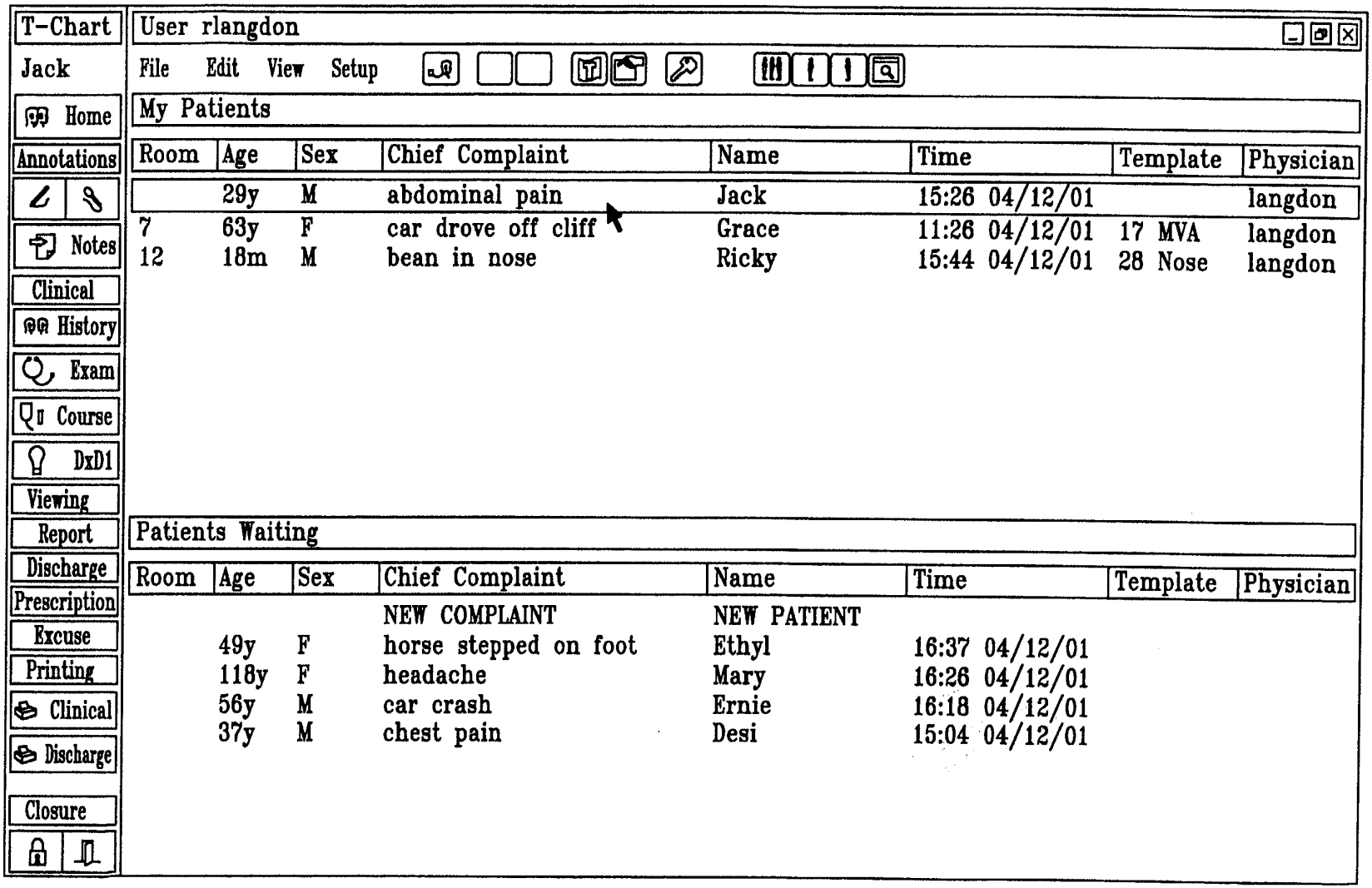

FIG. 6

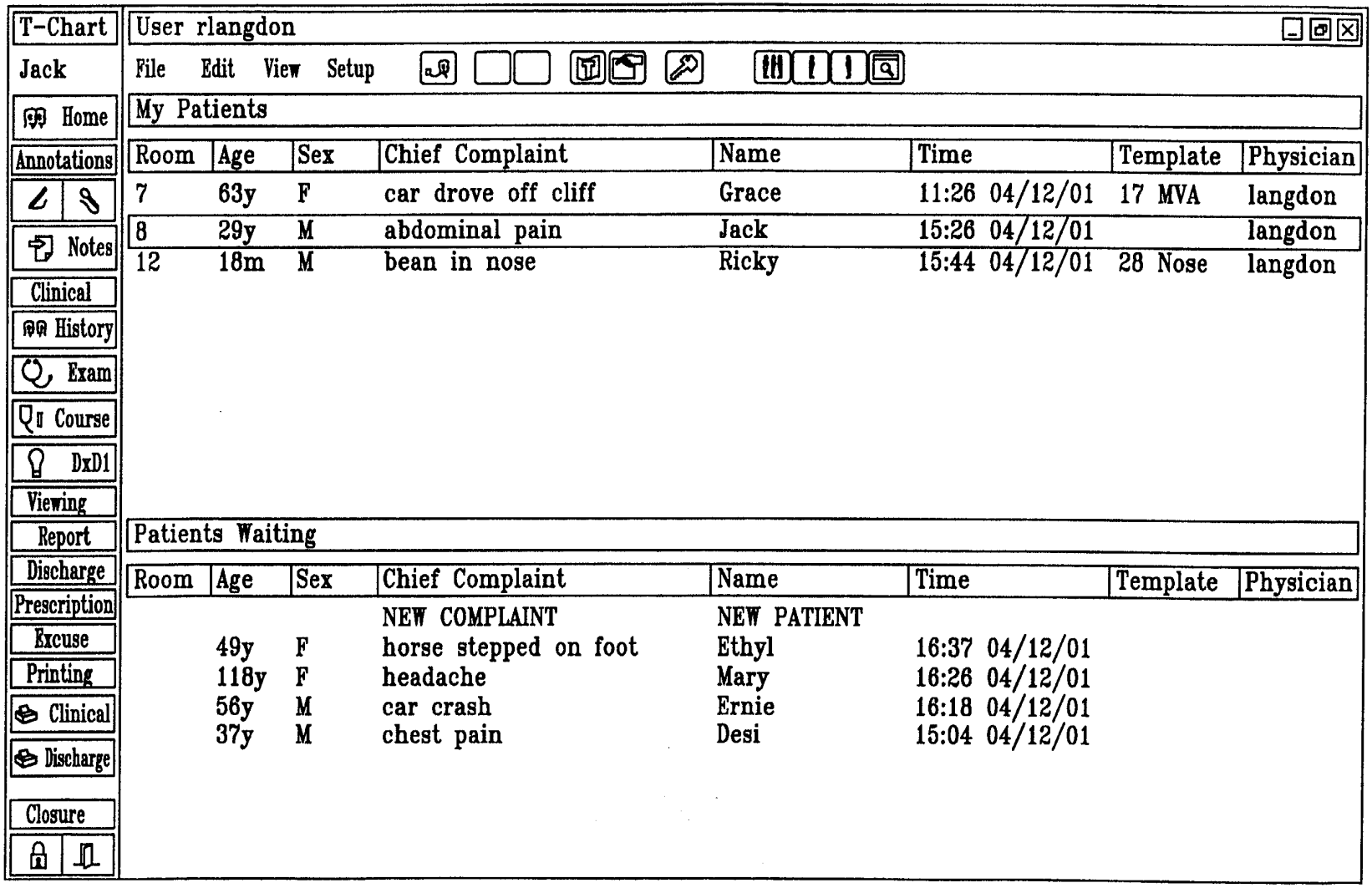

FIG. 7

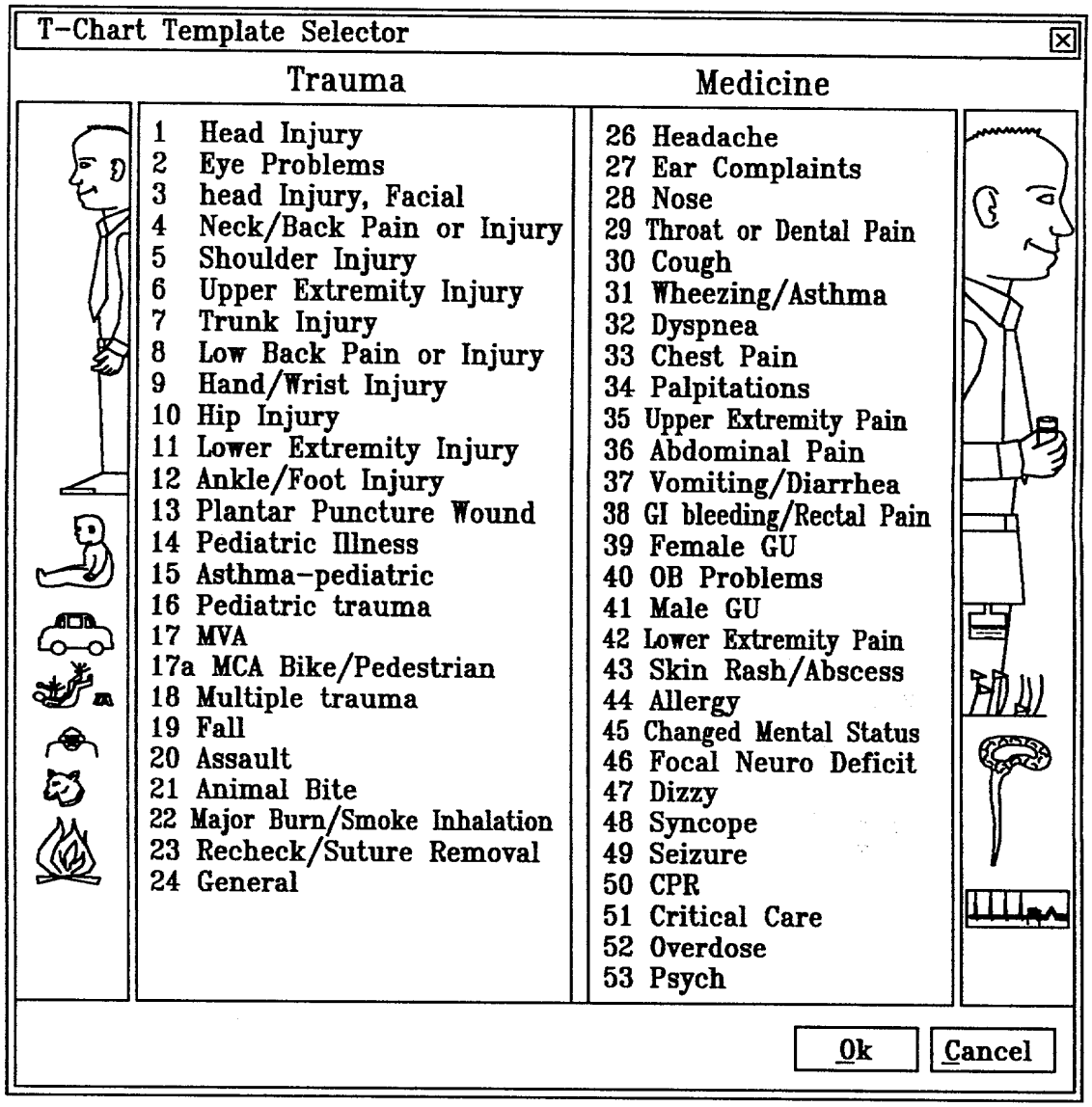
T-Chart Template Selector
Trauma
Medicine
1 Head Injury
2 Eye Problems
3 head Injury, Facial
4 Neck/Back Pain or Injury
5 Shoulder Injury
6 Upper Extremity Injury
7 Trunk Injury
8 Low Back Pain or Injury
9 Hand/Wrist Injury
10 Hip Injury
11 Lower Extremity Injury
12 Ankle/Foot Injury
13 Plantar Puncture Wound
14 Pediatric Illness
15 Asthma-pediatric
16 Pediatric trauma
17 MVA
17a MCA Bike/Pedestrian
18 Multiple trauma
19 Fall
20 Assault
21 Animal Bite
22 Major Burn/Smoke Inhalation
23 Recheck/Suture Removal
24 General
26 Headache
27 Ear Complaints
28 Nose
29 Throat or Dental Pain
30 Cough
31 Wheezing/Asthma
32 Dyspnea
33 Chest Pain
34 Palpitations
35 Upper Extremity Pain
36 Abdominal Pain
37 Vomiting/Diarrhea
38 GI bleeding/Rectal Pain
39 Female GU
40 OB Problems
41 Male GU
42 Lower Extremity Pain
43 Skin Rash/Abscess
44 Allergy
45 Changed Mental Status
46 Focal Neuro Deficit
47 Dizzy
48 Syncope
49 Seizure
50 CPR
51 Critical Care
52 Overdose
53 Psych
Ok
Cancel

FIG. 8

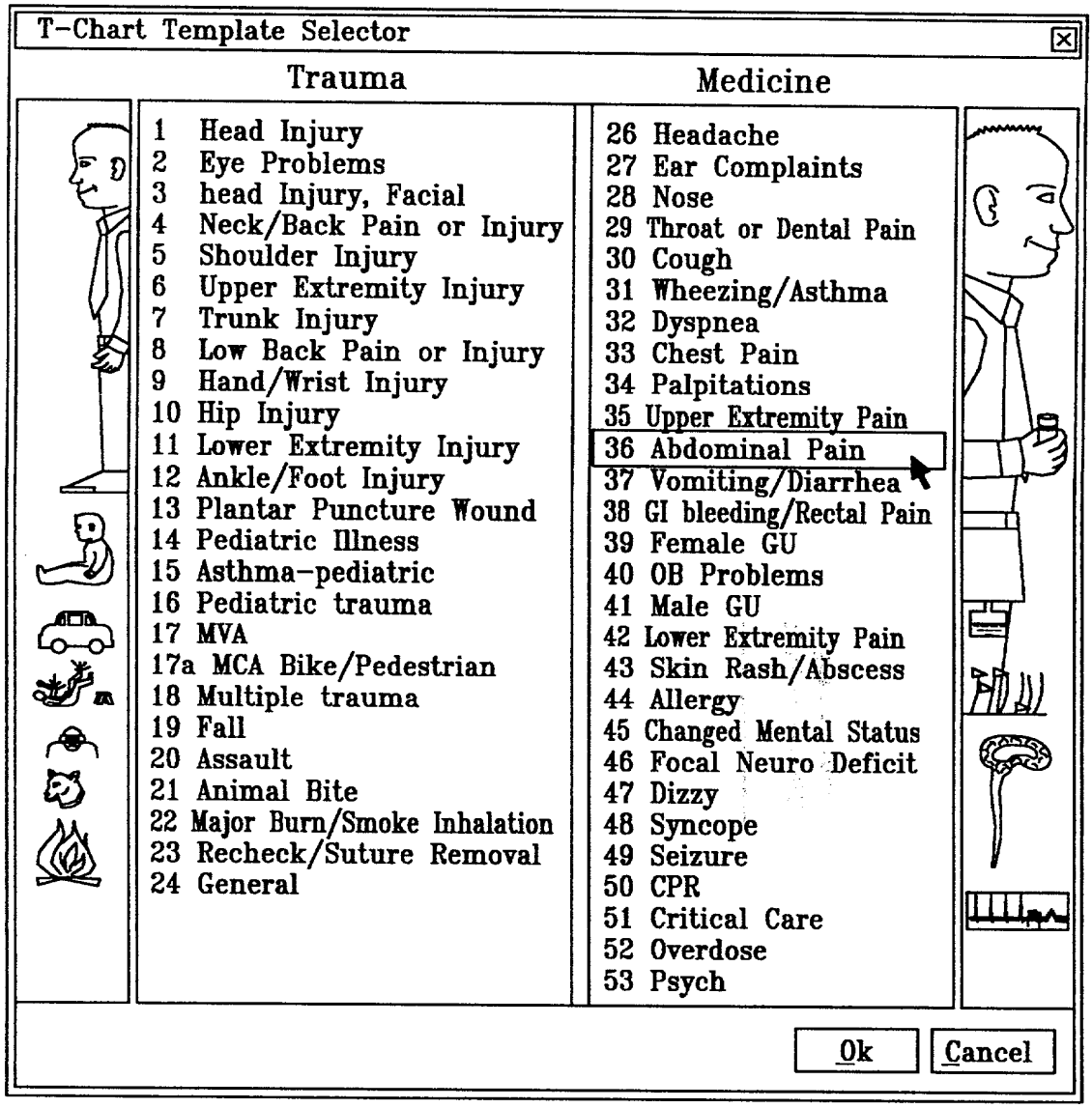

FIG. 9A

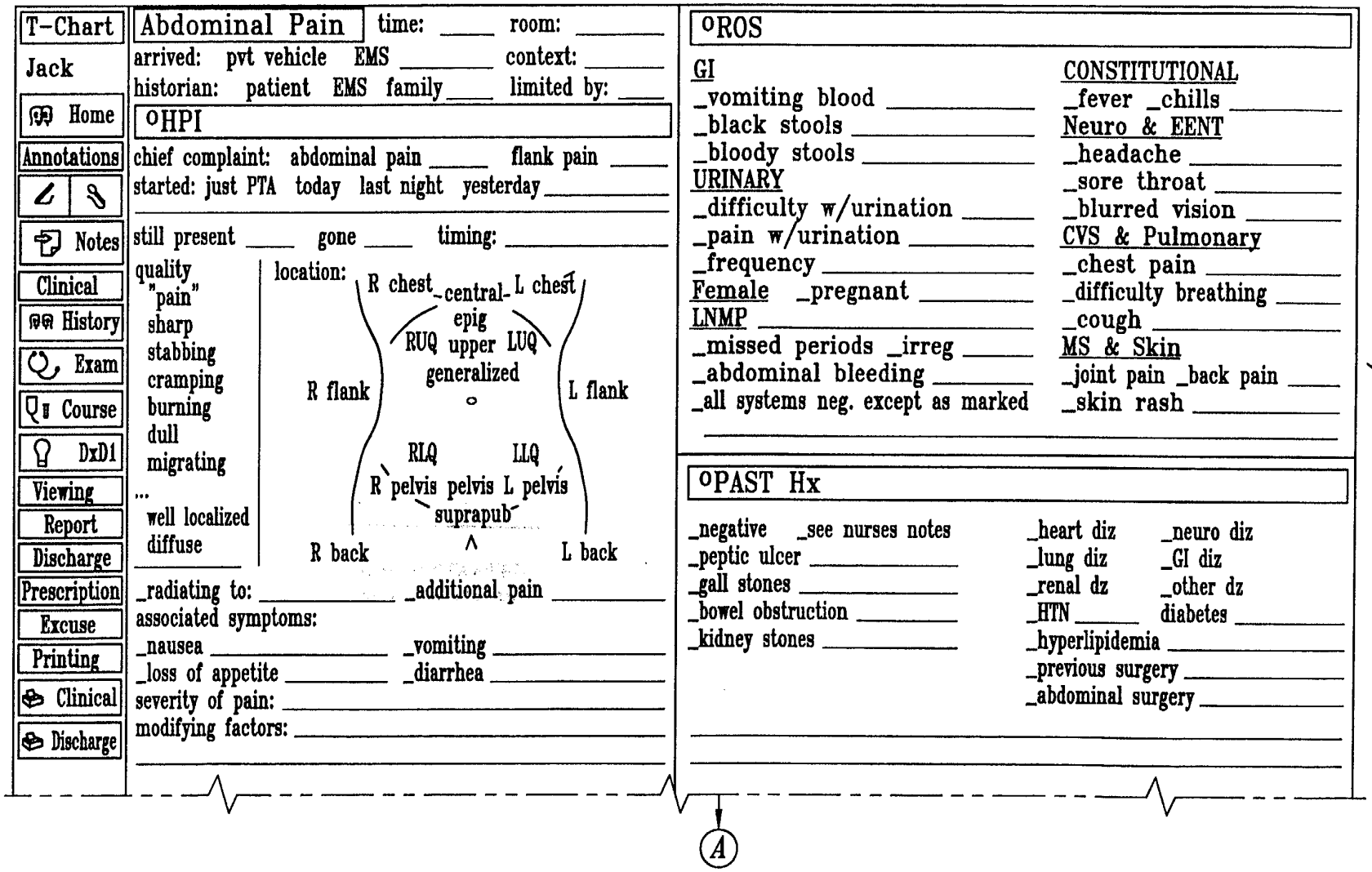

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FIG. 9B

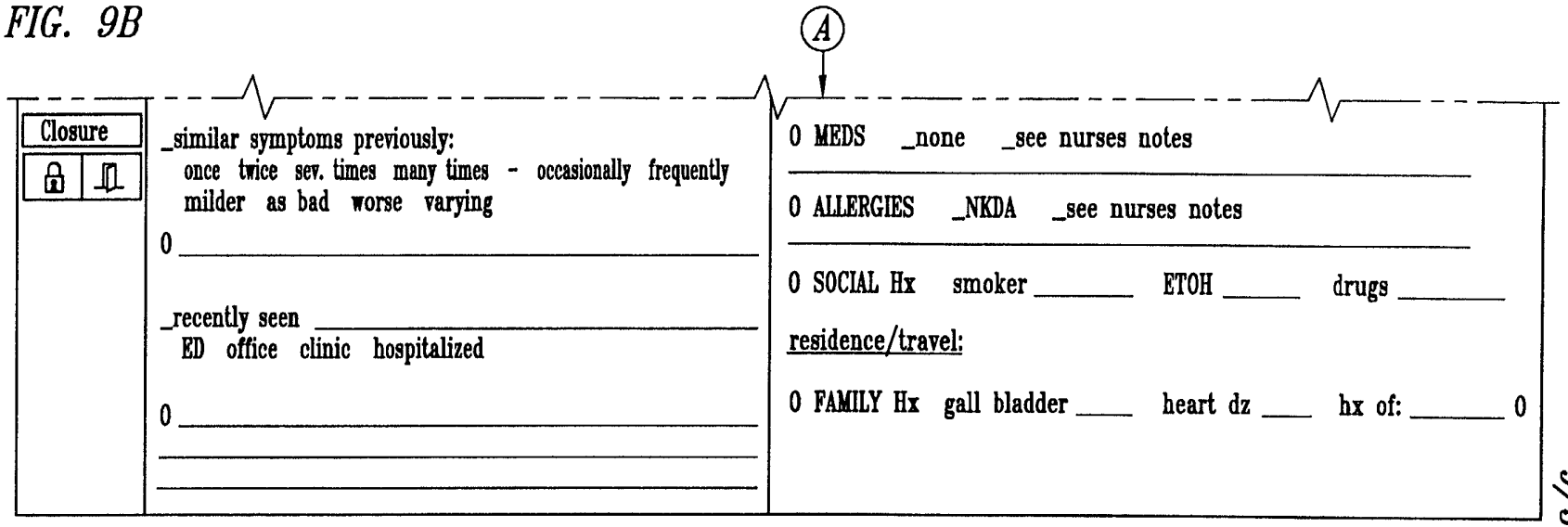

FIG. 10

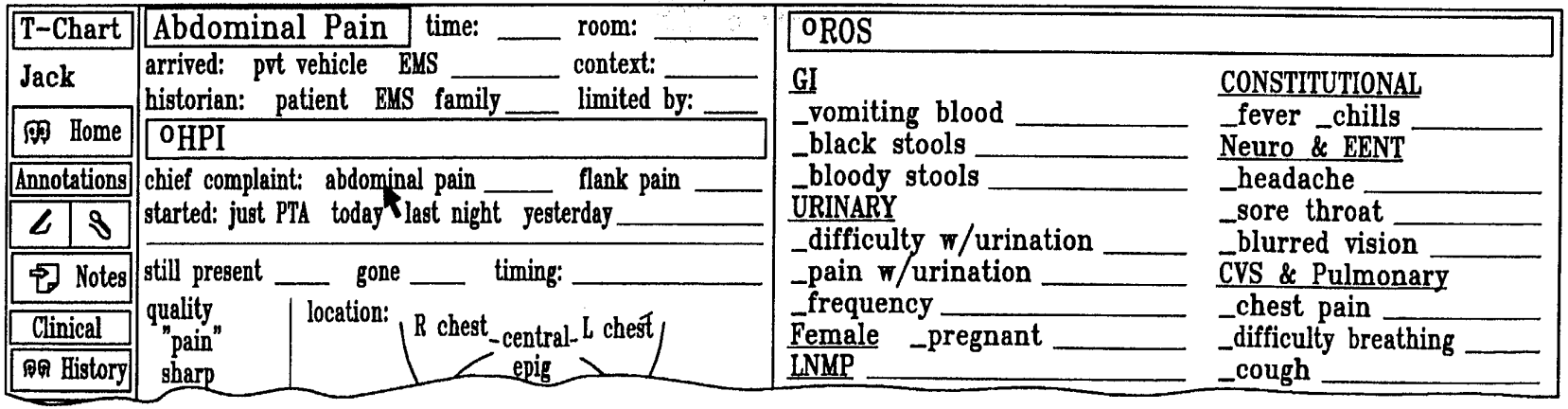

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FIG. 11

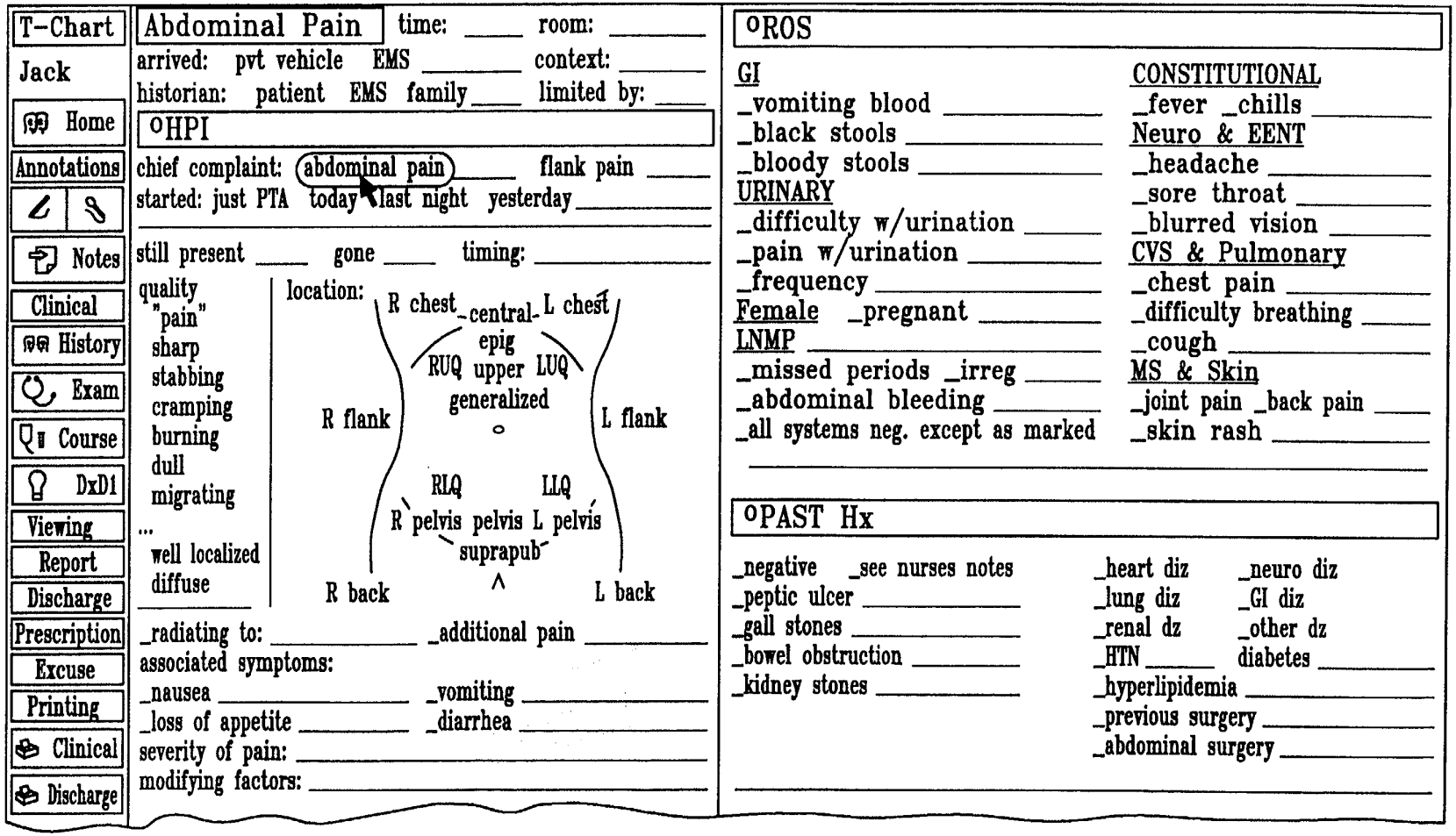

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FIG. 12

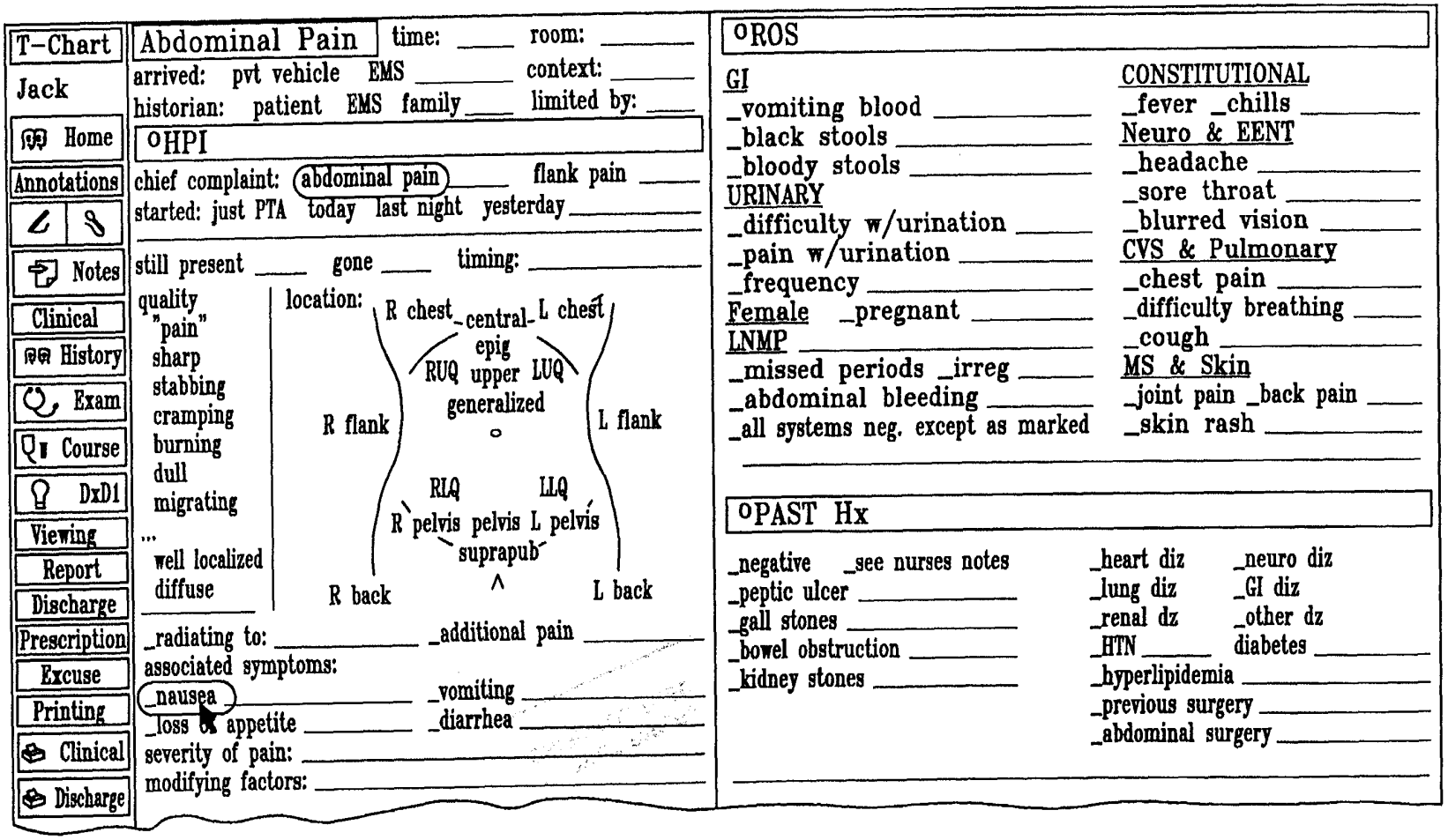

FIG. 13

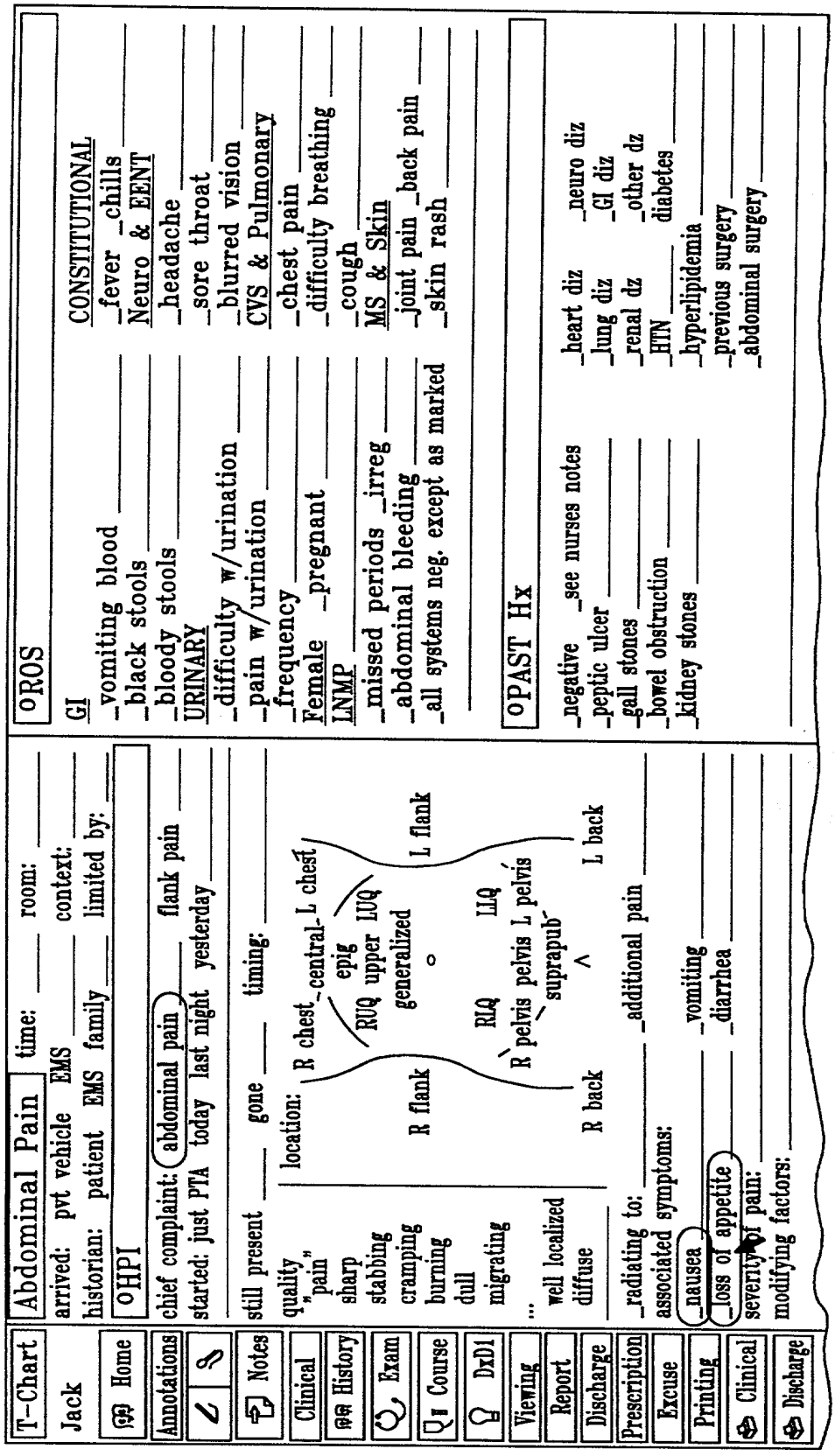
T-Chart
Jack
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Abdominal Pain
time:
room:
arrived: pvt vehicle EMS
context:
historian: patient EMS family
limited by:
OHPI
chief complaint: abdominal pain
flank pain
started: just PTA today last night yesterday
still present
gone
timing:
quality
"pain"
sharp
stabbing
cramping
burning
dull
migrating
...
well localized
diffuse
location:
R chest
central
L chest
epig
RUQ upper LUQ
generalized
R flank
L flank
RLQ
LLQ
R pelvis pelvis L pelvis
suprapub
R back
L back
radiating to:
additional pain
associated symptoms:
nausea
vomiting
loss of appetite
diarrhea
severity of pain:
modifying factors:
OROS
GI
vomiting blood
black stools
bloody stools
URINARY
difficulty w/urination
pain w/urination
frequency
Female
pregnant
LNMP
missed periods
irreg
abdominal bleeding
all systems neg. except as marked
CONSTITUTIONAL
fever
chills
Neuro & EENT
headache
sore throat
blurred vision
CVS & Pulmonary
chest pain
difficulty breathing
cough
MS & Skin
joint pain
back pain
skin rash
OPAST Hx
negative
see nurses notes
peptic ulcer
gall stones
bowel obstruction
kidney stones
heart diz
lung diz
renal dz
HTN
hyperlipidemia
neuro diz
GI diz
other dz
diabetes
previous surgery
abdominal surgery

FIG. 14

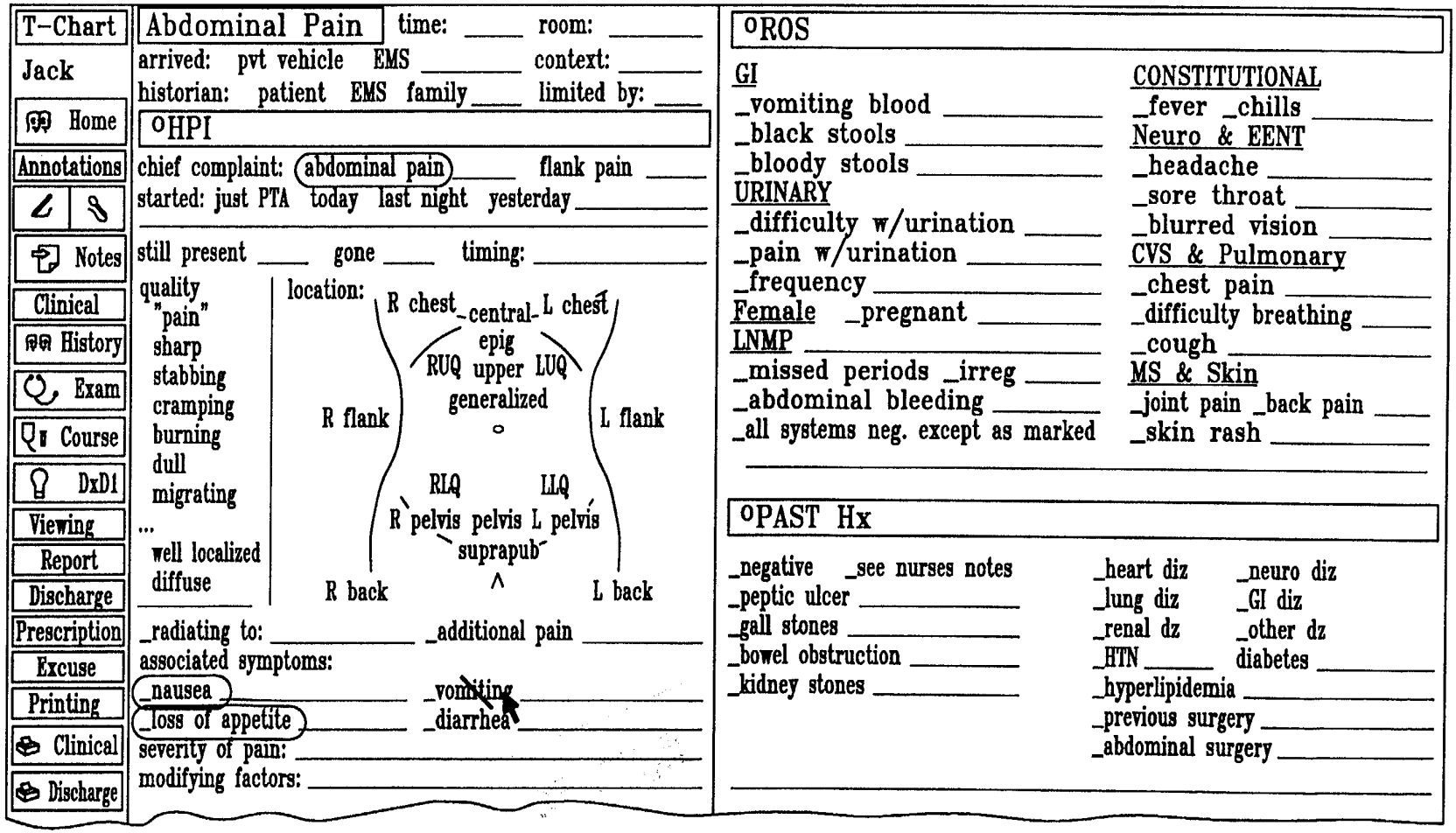

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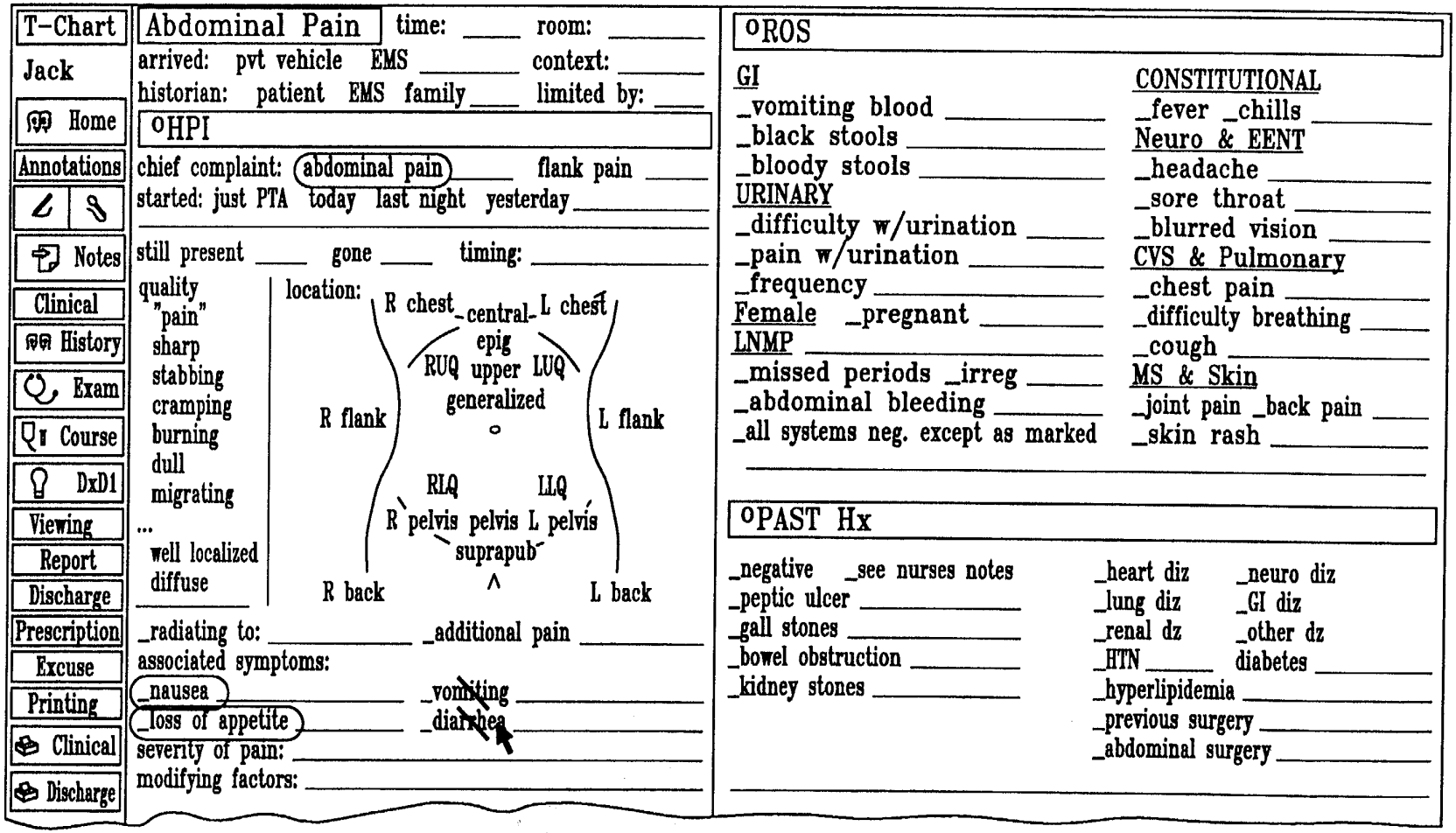
FIG. 15



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Inventor(s): Woodrow W. Gandy et al
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FIG. 16

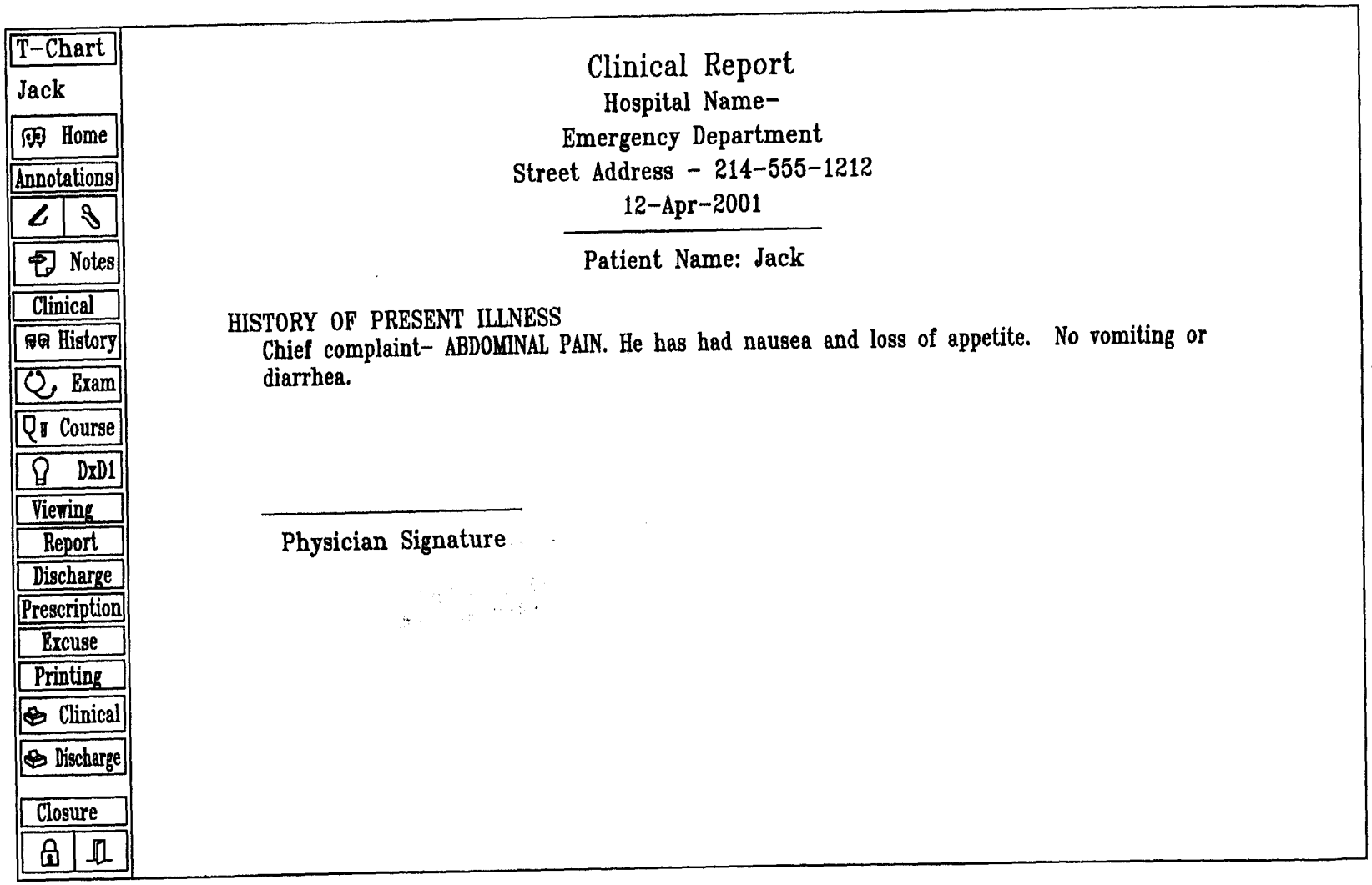
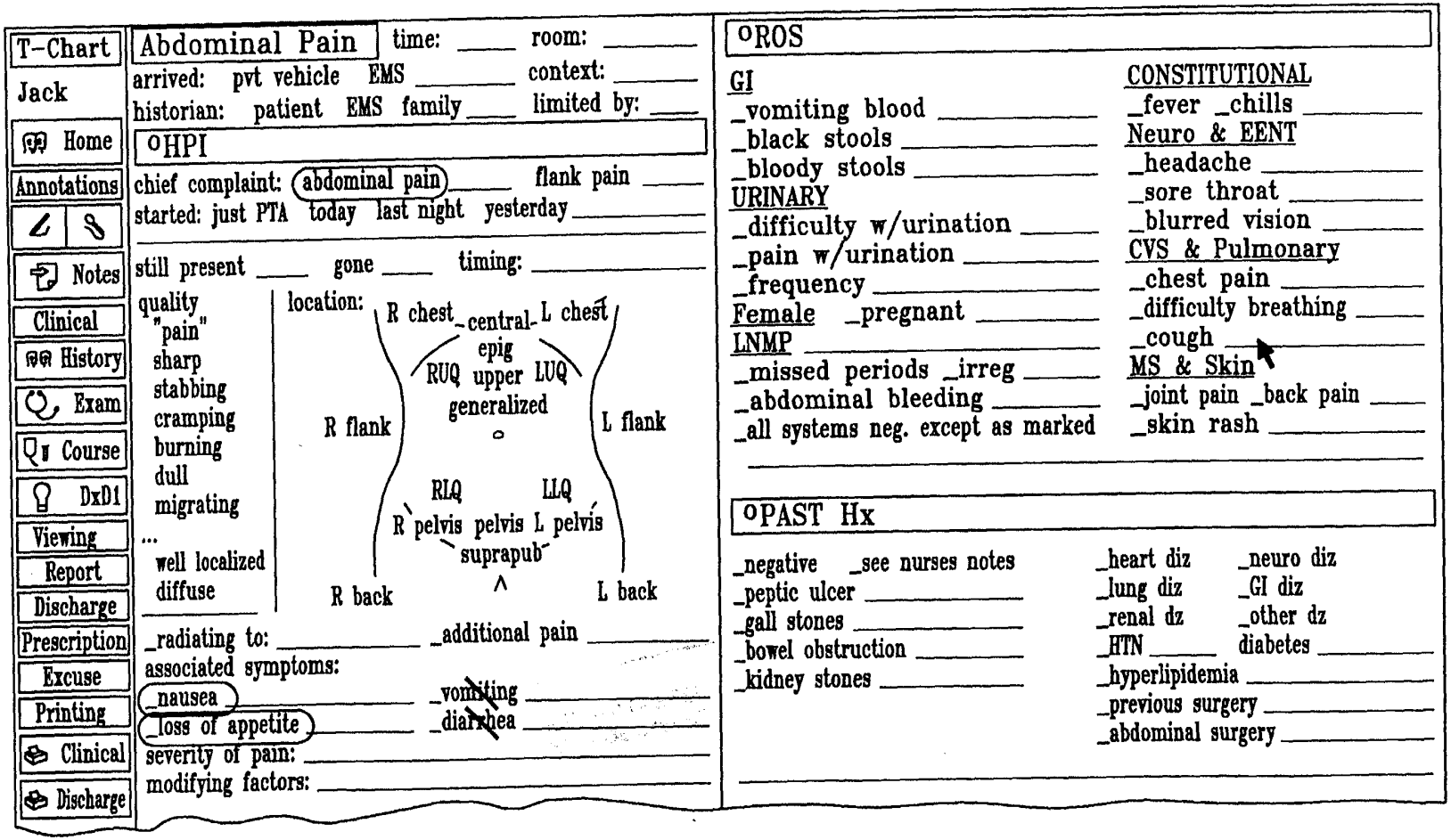


FIG. 17



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Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 18

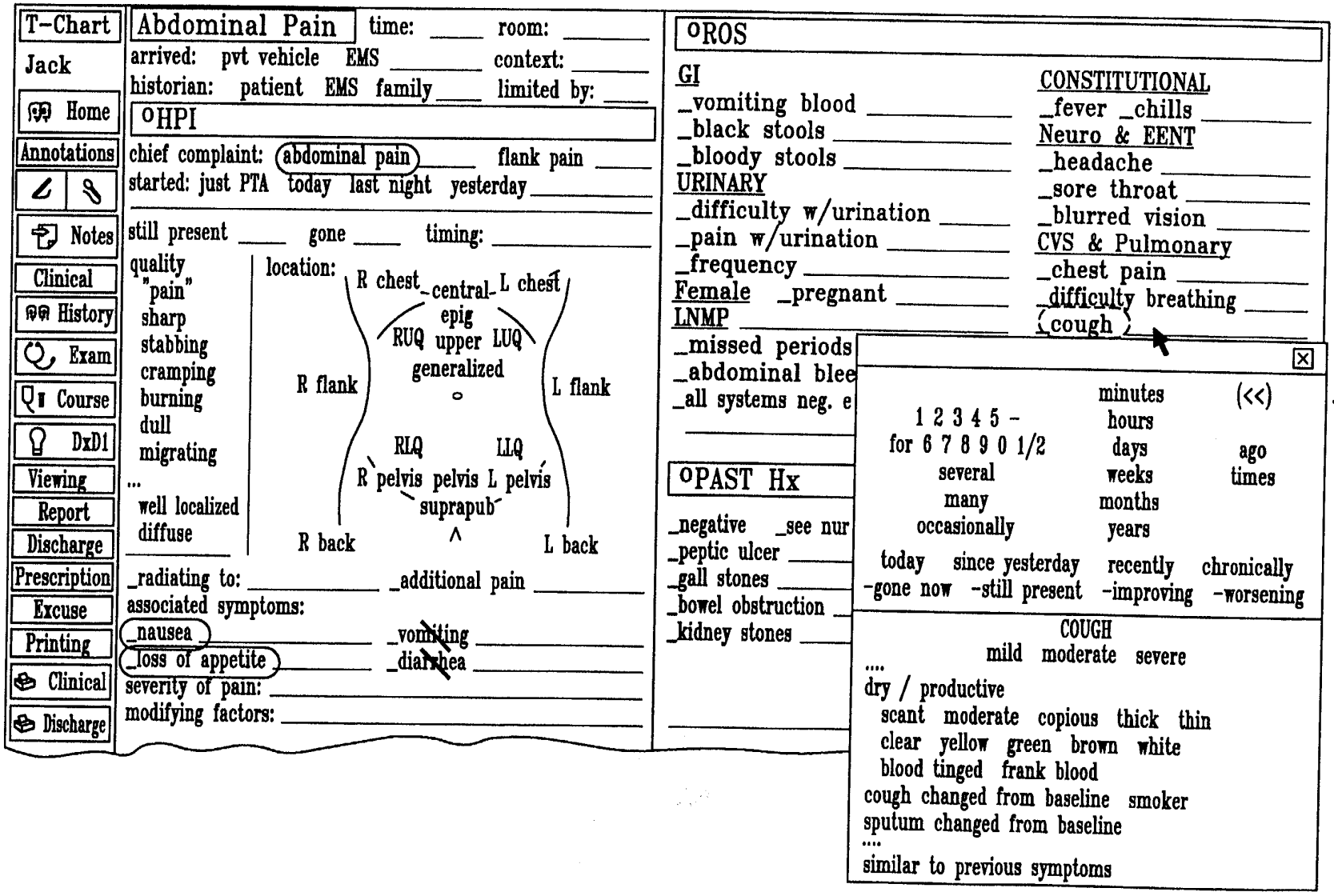

FIG. 19

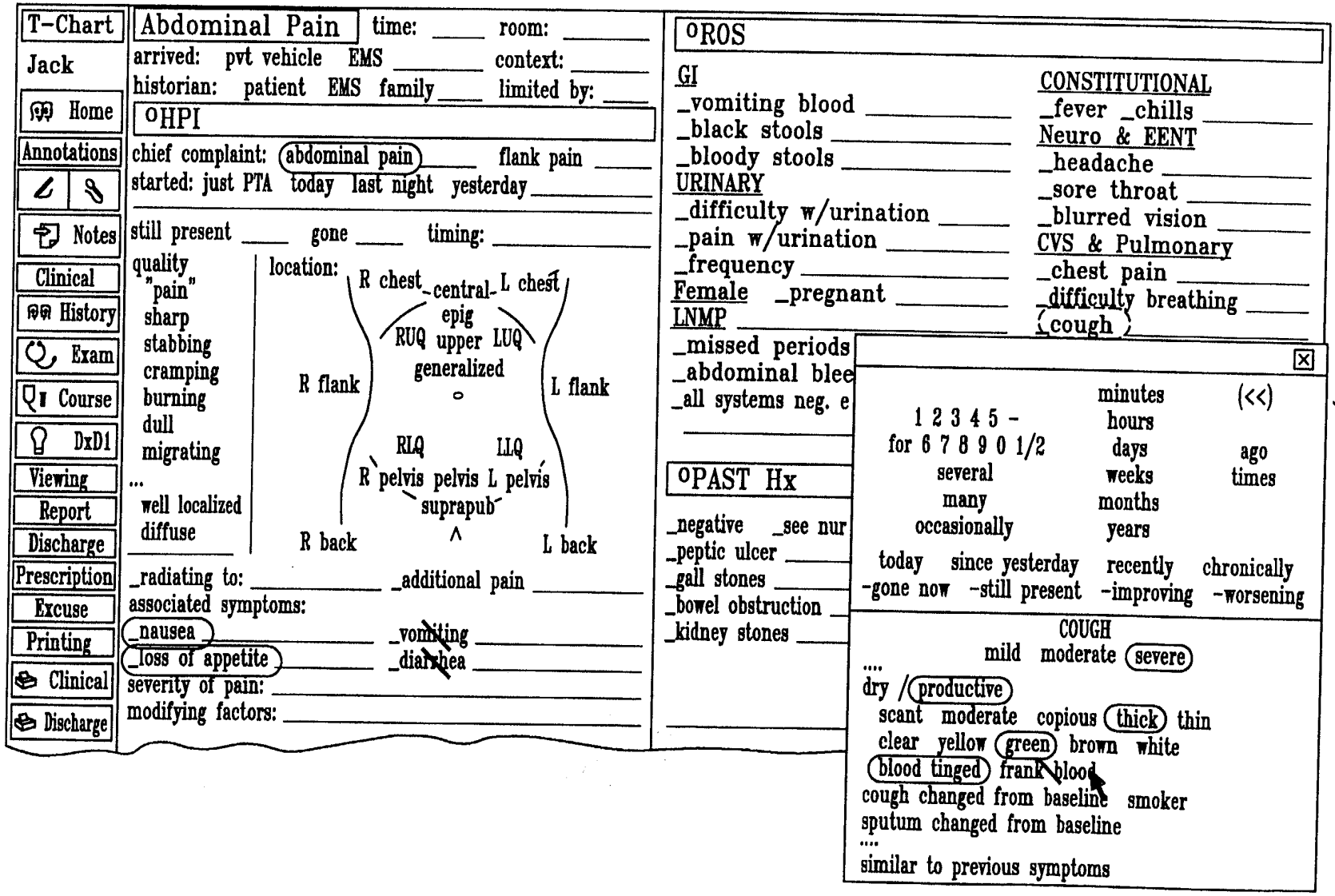

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FIG. 20

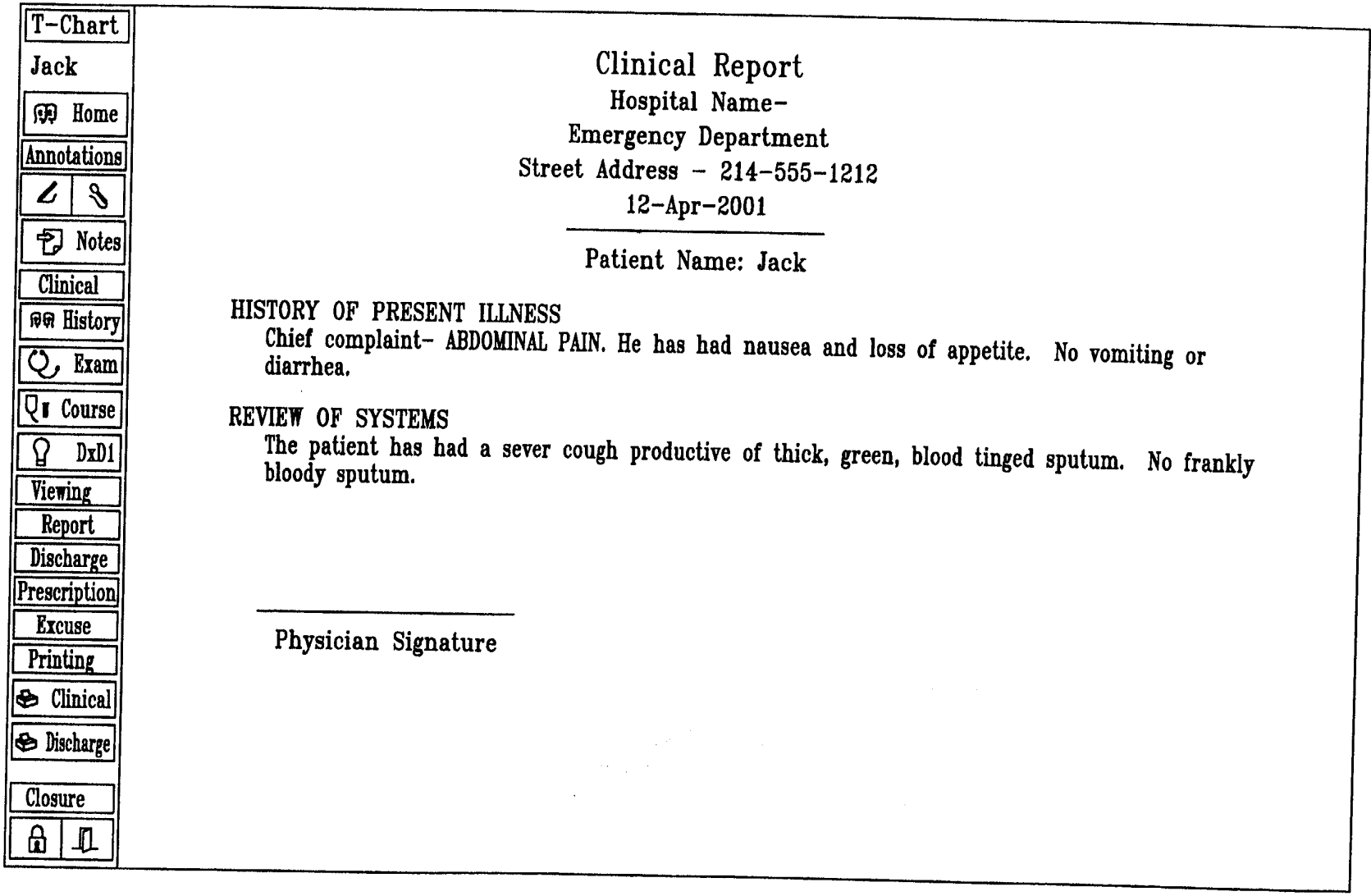
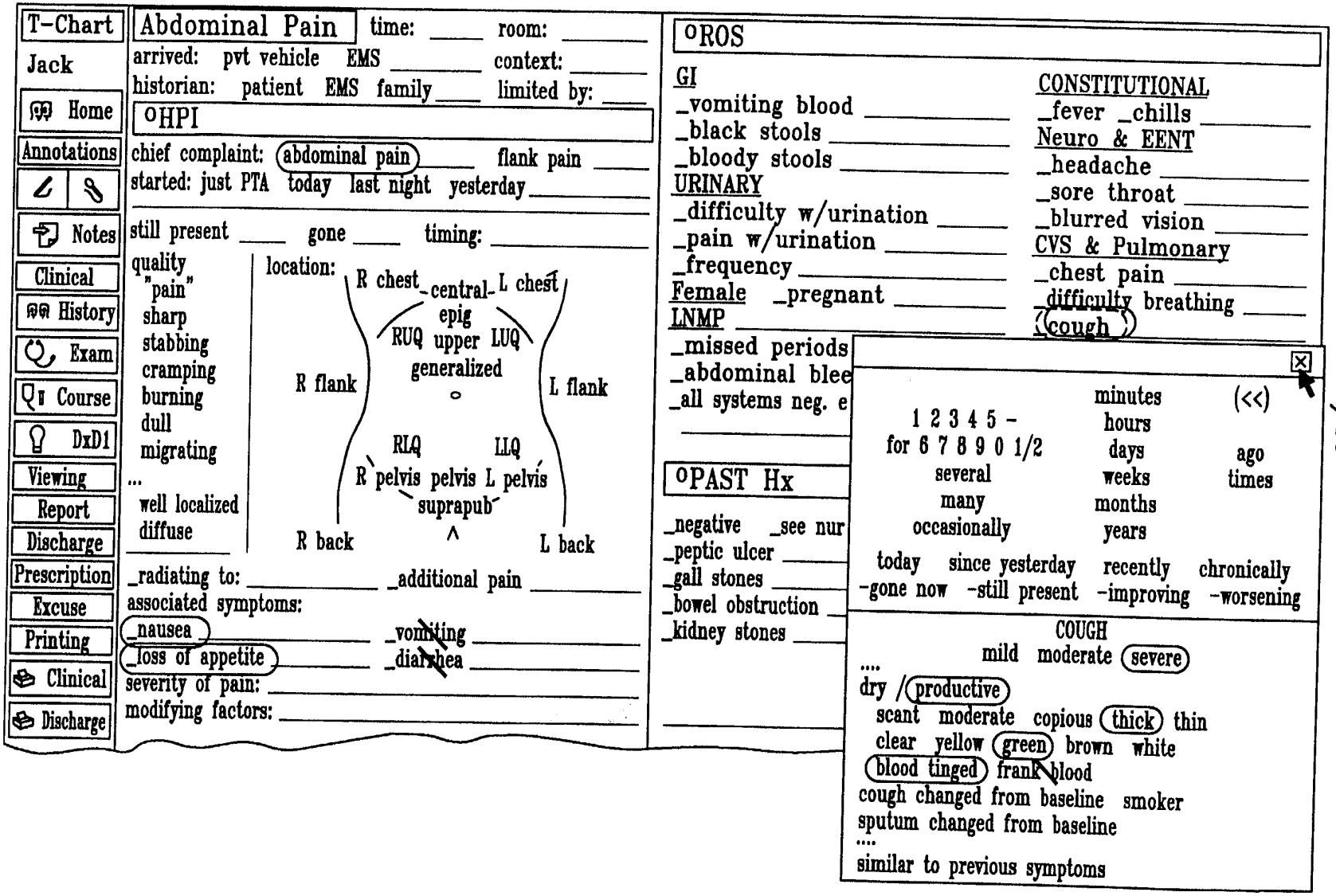

T-Chart
Jack
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
Clinical Report
Hospital Name-
Emergency Department
Street Address - 214-555-1212
12-Apr-2001
Patient Name: Jack
HISTORY OF PRESENT ILLNESS
Chief complaint- ABDOMINAL PAIN. He has had nausea and loss of appetite. No vomiting or diarrhea.
REVIEW OF SYSTEMS
The patient has had a sever cough productive of thick, green, blood tinged sputum. No frankly bloody sputum.
Physician Signature

FIG. 21



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Inventor(s): Woodrow W. Gandy et al
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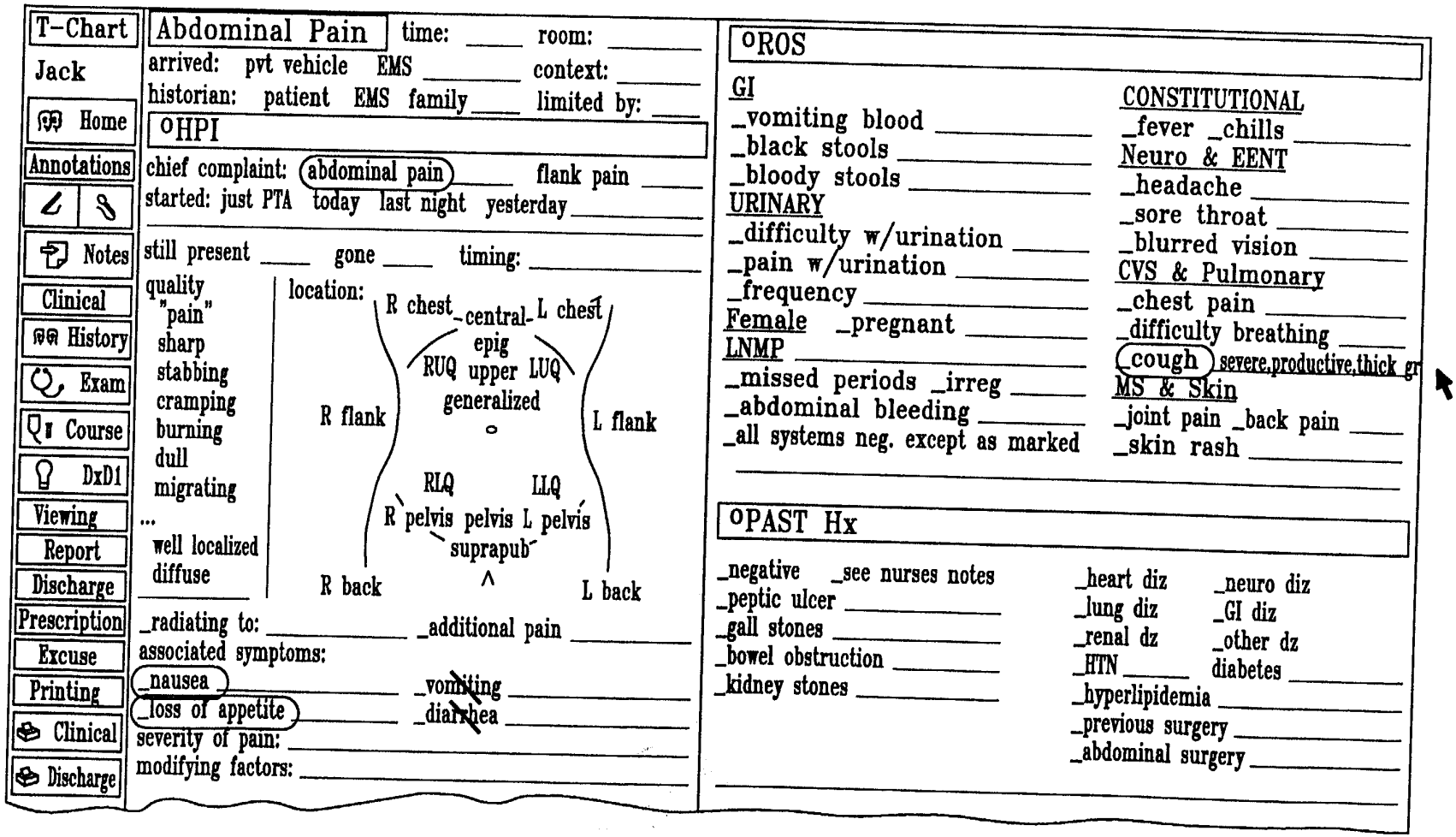
FIG. 22



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Inventor(s): Woodrow W. Gandy et al
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FIG. 23

T-Chart
Jim
Home
Annotations
Notes
Clinical History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure

MVA time: ____ room: ____
arrived: pvt vehicle EMS ____ context: ____
historian: patient EMS family ____ limited by: ____

OHPI
chief complaint: MVA ____
location of injuries: ____
occurred: just PTA today last night yesterday ____
pain: none ____ mild ____ moderate ____ severe ____
assoc: blow head ___ neck pain ___ LOC ___ dazed ___ seizure ___
mechanism details: 0

OROS
_numbness _weakness___ _trouble breathing ____
_hearing loss ____ _nausea _vomiting ____
_loss of vision ____ _bladder dysfunction ____
_headache ____ _skin laceration ____
_chest pain ____ _fever _recently ill ____
_depressed ____ _all systems neg. except as marked

OPAST HISTORY
_neg _see nurses notes _heart dz _neuro dz ____
tetenus: UTD >5 >10 unk ___ _lung dz _GI dz ____
____ _renal dz _other dz ____
____ _HTN ___ diabetes ____
____ _previous surgery ____
0 MEDS _none _see nurses notes ____
0 ALLERGIES _NKDA _see nurses notes ____

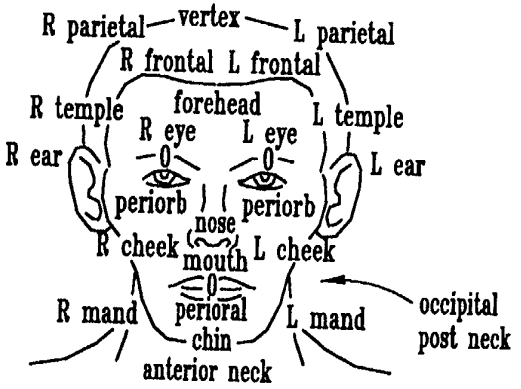
0 SOCIAL HX smoker____ ETOH ____ drugs ____
residence/travel: ____ 0

bkbrd c-collar____ nurses notes rev'd ____ VS rev'd ____

PHYSICAL EXAM

_alert
_NAD
_anxious / lethargic / obtunded ____
_in distress mild mod severe ____

HEAD
_non-tender
_no swelling
_Battle's sign ____ raccoon eyes ____



Add'l Injury 0

NECK
_non-tender
_painless ROM
_verteb. tenderness ___ painful movement ____
_decrsd ROM ____ muscle spasm ____

EYES
_PERRL
_EOM intact
_pupillary exam: ____
_ocular injury ____
_abnml fundiscopic ____

ENT
_no dental injury
_phatynx nml
_hematympanum ____
_malocclusion ____

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FIG. 24

T-Chart
Jim
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure

RESPIRATORY
_chest nontender
_breath snds nml
_resp distress
_chest wall injury #1 #2
_decreased breath sounds
_rales rhonchi
_wheezes crepitus

CVS
_heart snds nml
_pulses nml
_abnml rate techycardia bradycardia
_abnml rhythm
_JVD present
_extra sounds murmur
_pulse exam

ABDOMEN
_soft
_nontender
_no organomegaly
_obese scar other
_tenderness #1 #2
_guarding
_rebound
_organomegaly gravid uterus
_abnml bowel sounds
_distention
_mass

GU
_nml genitalia
_nml vaginal exam
_panneal hematoma
_blood at urethral meatus

RECTAL
_nml rectal exam
_heme neg stool
_blood in stool
_abnormal digital rectal

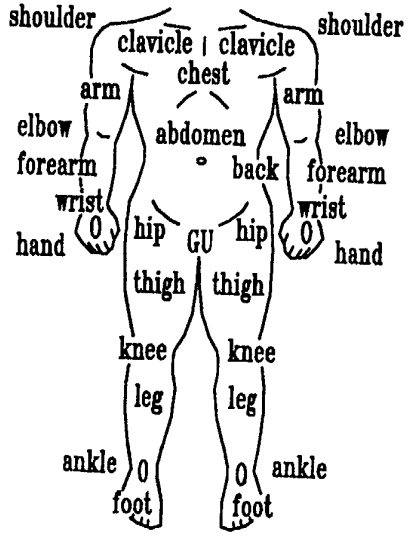
BACK
_nontender
_ROM nml
_tenderness #2
_vertebral point tenderness
_muscle spasm limited ROM

0 NEURO
_oriented x3
_no motor deficit
_no sensory deficit
_reflexes nml
_altered mental status GCS
_CN deficit
_weakness sensory deficit
_reflex exam:

SKIN
_intact
_warm, dry
_nml color
_cyanosis pallor
_cool skin diaphoresis
_skin rash poor skin turgor

EXTREMITIES
_atraumatic
_nml inspection
_pelvis stable
_no pedal edema
_soft tissue tenderness
_bony tenderness
_abrasions #1 #2
_limping gait cannot bear weight
_gait not tested due to pain

RT



LT

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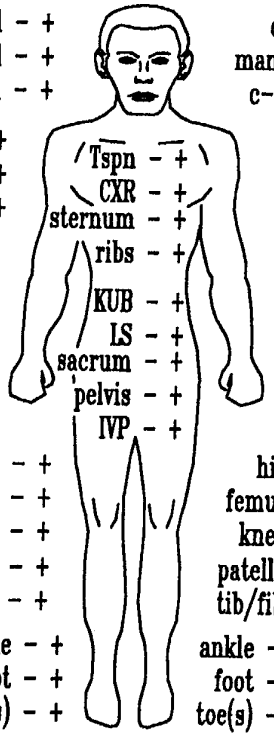
FIG. 25

T-Chart
Jim
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure

X-RAYS

_nml / NAD except as noted _____
_independently visualized by me _discussed with radiologist
_interpreted by me contemporaneously _interpreted by radiologist



R
skull - +
facial - +
nasal - +
clavicle - +
scapula - +
shoulder - +
humerous - +
elbow - +
forearm - +
wrist - +
hand - +
digit - +
hip - +
femur - +
knee - +
patella - +
tib/fib - +
ankle - +
foot - +
toe(s) - +

Tspn - +
CXR - +
sternum - +
ribs - +
KUB - +
LS - +
sacrum - +
pelvis - +
IVP - +

L
orbits - +
mandible - +
c-spine - +
clavicle - +
scapula - +
shoulder - +
humerous - +
elbow - +
forearm - +
wrist - +
hand - +
digit - +
hip - +
femur - +
knee - +
patella - +
tib/fib - +
ankle - +
foot - +
toe(s) - +

EKG / LABS / SPECIAL STUDIES

0 EKG _nml
0 Labs _nml
0 CT Head _NAD
0 CT Chest _NAD
0 CT Abdomen _NAD
0 Other studies _neg

o PROCEDURE NOTES

0 Intubation
0 Ventilator Management
0 Central Line
0 Chest Tube
0 Splint
0 Wound Repair

PROGRESS

TIME _____ -now- stable unstable
sx's much better better unchng'd
exam improved unchanged
[APPLY]

0 trauma course 0 Resp / CVS 0 CPR 0 re-evaluation

consultation / review of records

_D/W Dr. _____
_D/W Dr. (#2) _____
_tried - can't contact Dr. ____
_family consultation _____
_old records ordered _____
_old records reviewed _____
_records req - unavailable ___
_further history sought _____

hospital admission or transfer

_admitted _____
_transferred _____
_observation status _____
_good condition _____
_stable _____

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FIG. 26

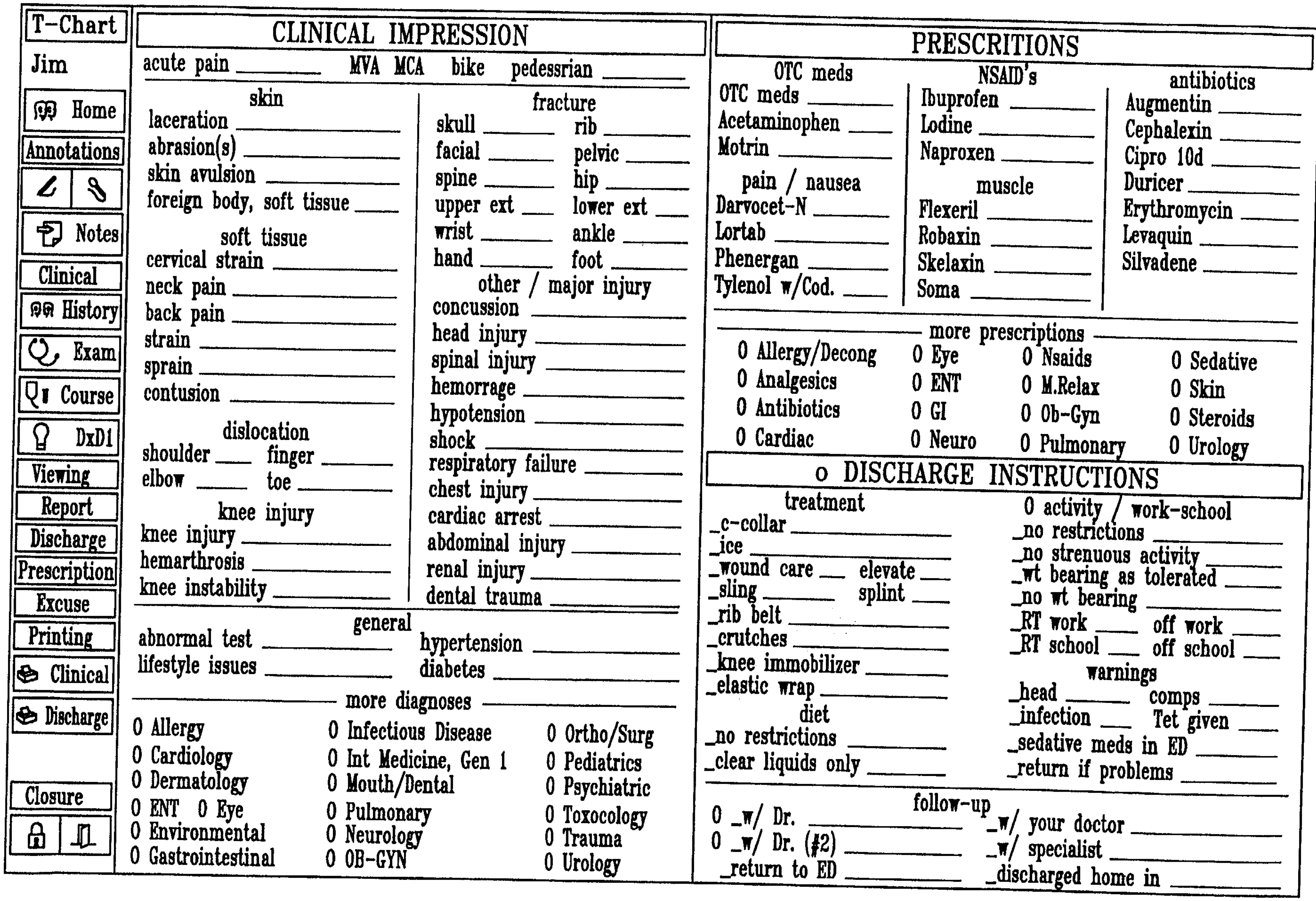
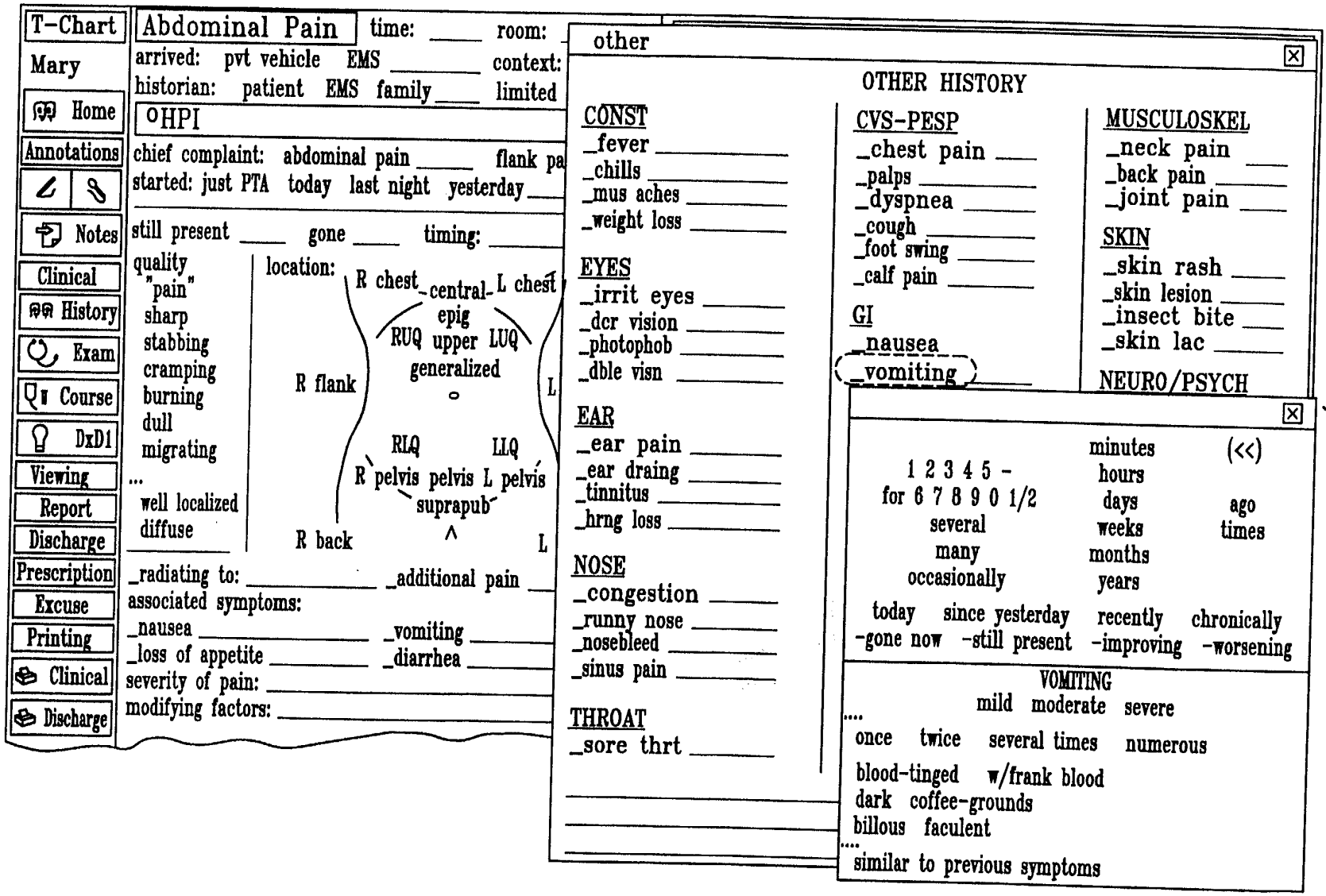

T-Chart
Jim
Home
Annotations
Notes
Clinical
History
Exam
Course
DxD1
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
CLINICAL IMPRESSION
acute pain
MVA MCA bike pedessrian
skin
laceration
abrasion(s)
skin avulsion
foreign body, soft tissue
soft tissue
cervical strain
neck pain
back pain
strain
sprain
contusion
dislocation
shoulder
finger
elbow
toe
knee injury
knee injury
hemarthrosis
knee instability
fracture
skull
rib
facial
pelvic
spine
hip
upper ext
lower ext
wrist
ankle
hand
foot
other / major injury
concussion
head injury
spinal injury
hemorrage
hypotension
shock
respiratory failure
chest injury
cardiac arrest
abdominal injury
renal injury
dental trauma
general
abnormal test
lifestyle issues
hypertension
diabetes
more diagnoses
0 Allergy
0 Cardiology
0 Dermatology
0 ENT 0 Eye
0 Environmental
0 Gastrointestinal
0 Infectious Disease
0 Int Medicine, Gen 1
0 Mouth/Dental
0 Pulmonary
0 Neurology
0 OB-GYN
0 Ortho/Surg
0 Pediatrics
0 Psychiatric
0 Toxocology
0 Trauma
0 Urology
PRESCRIPTIONS
OTC meds
OTC meds
Acetaminophen
Motrin
pain / nausea
Darvocet-N
Lortab
Phenergan
Tylenol w/Cod.
NSAID's
Ibuprofen
Lodine
Naproxen
muscle
Flexeril
Robaxin
Skelaxin
Soma
antibiotics
Augmentin
Cephalexin
Cipro 10d
Duricer
Erythromycin
Levaquin
Silvadene
more prescriptions
0 Allergy/Decong
0 Analgesics
0 Antibiotics
0 Cardiac
0 Eye
0 ENT
0 GI
0 Neuro
0 Nsaids
0 M.Relax
0 Ob-Gyn
0 Pulmonary
0 Sedative
0 Skin
0 Steroids
0 Urology
o DISCHARGE INSTRUCTIONS
treatment
_c-collar
_ice
_wound care
elevate
_sling
splint
_rib belt
_crutches
_knee immobilizer
_elastic wrap
diet
_no restrictions
_clear liquids only
0 activity / work-school
_no restrictions
_no strenuous activity
_wt bearing as tolerated
_no wt bearing
_RT work
off work
_RT school
off school
warnings
_head
comps
_infection
Tet given
_sedative meds in ED
_return if problems
follow-up
0 _w/ Dr.
0 _w/ Dr. (#2)
_return to ED
_w/ your doctor
_w/ specialist
_discharged home in

FIG. 27



TSYS 25,410
Title: METHOD FOR ENTERING, RECORDING, DISTRIBUTING AND REPORTING DATA
Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

FIG. 28A

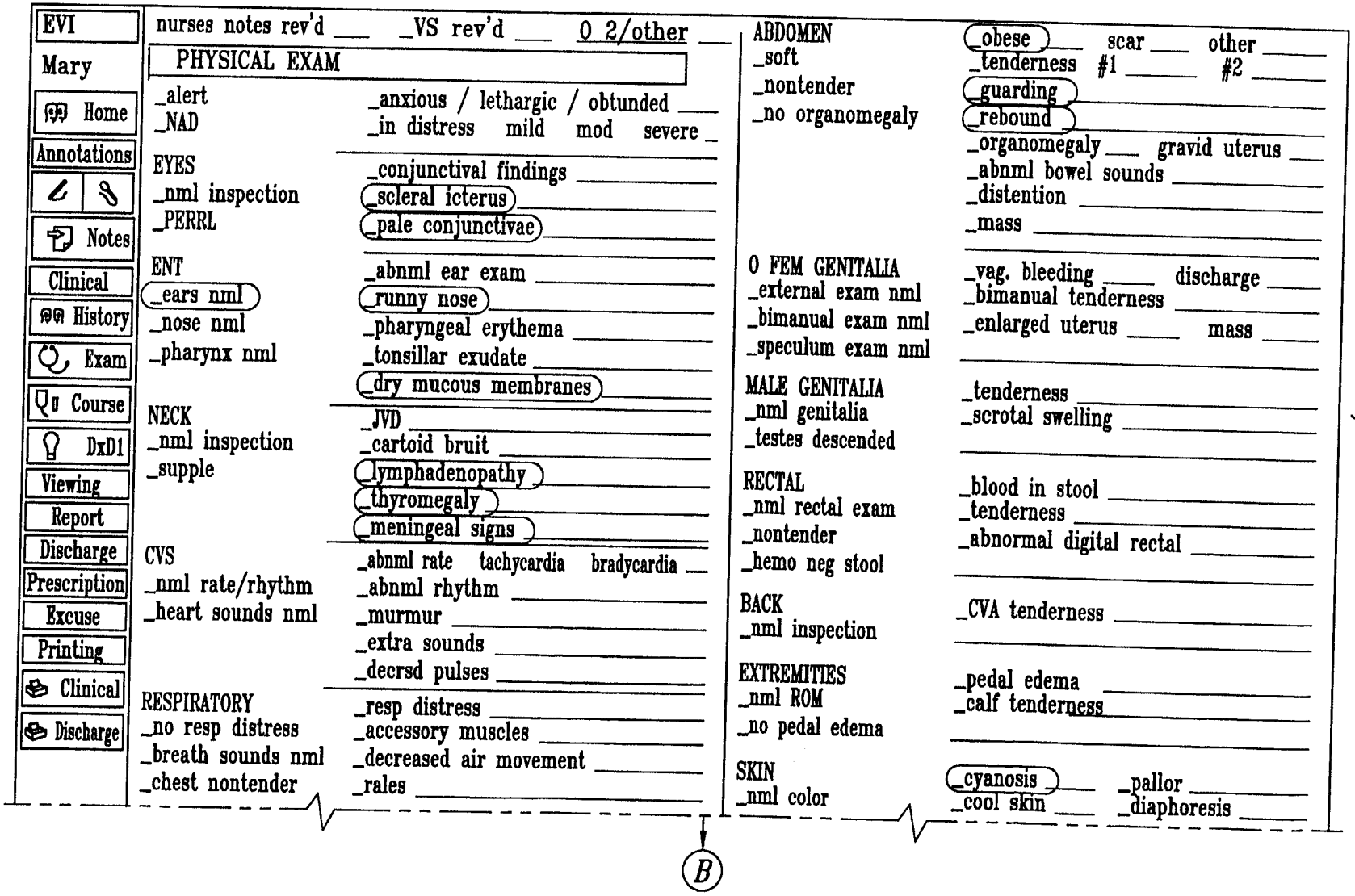


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FIG. 28B

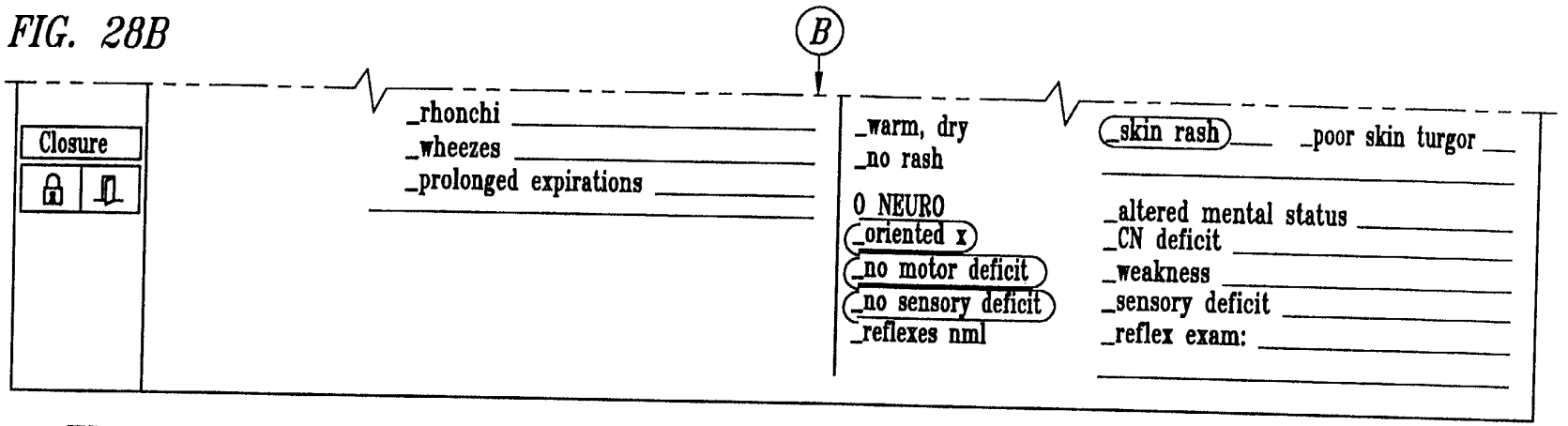


FIG. 29

Clinical Report

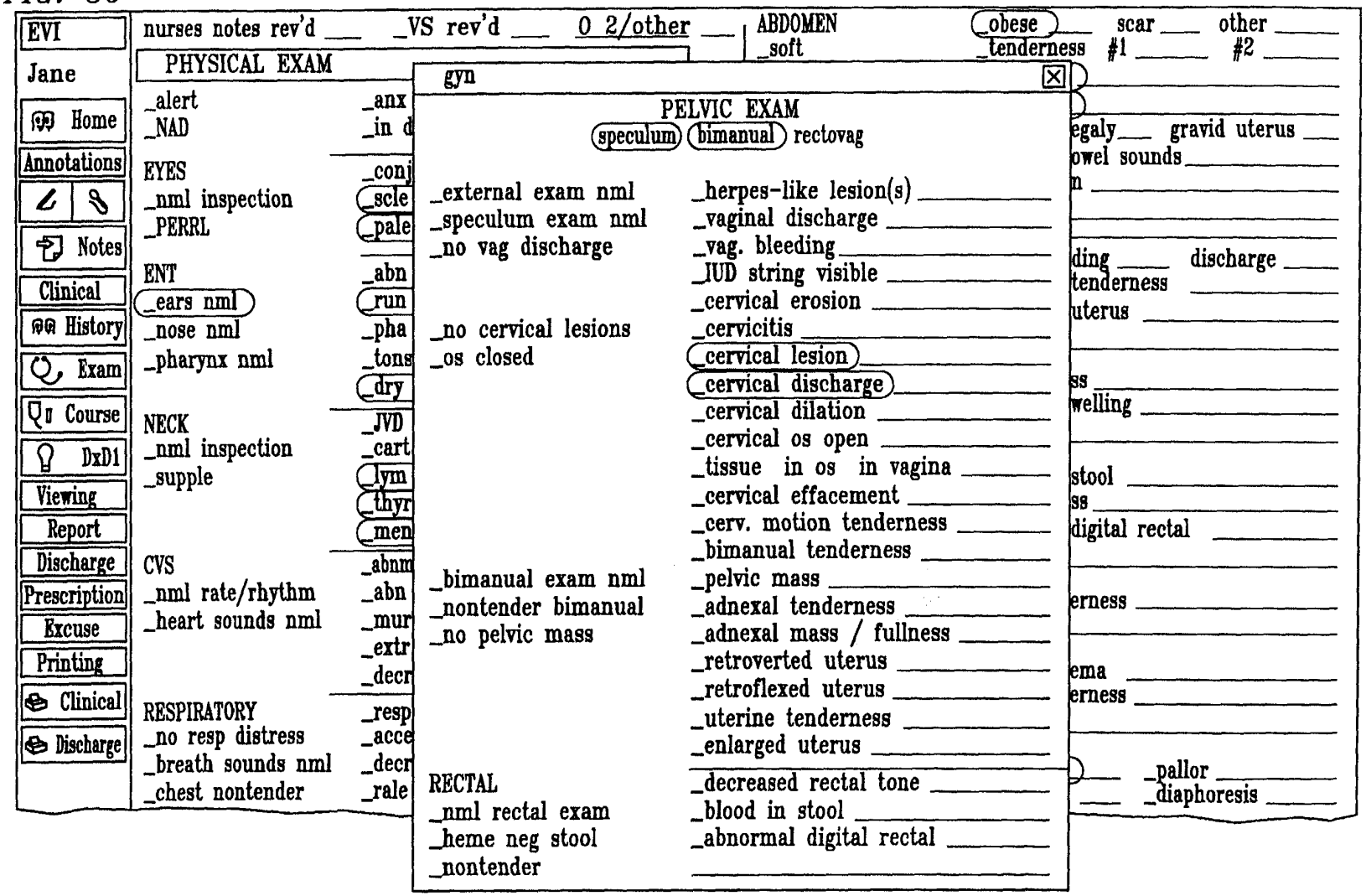
Hospital Name - Emergency Department
Street Address - 214-555-1212
12-Apr-2001

Patient Name: Mary

PHYSICAL EXAM
Eyes: Scleral icterus. Pale conjunctivae.
ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.
Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.
Abdomen: Obese. Rebound tenderness. Guarding present.
Skin: Cyanosis. Skin rash.
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

Physician Signature

FIG. 30



TSYS 25,410
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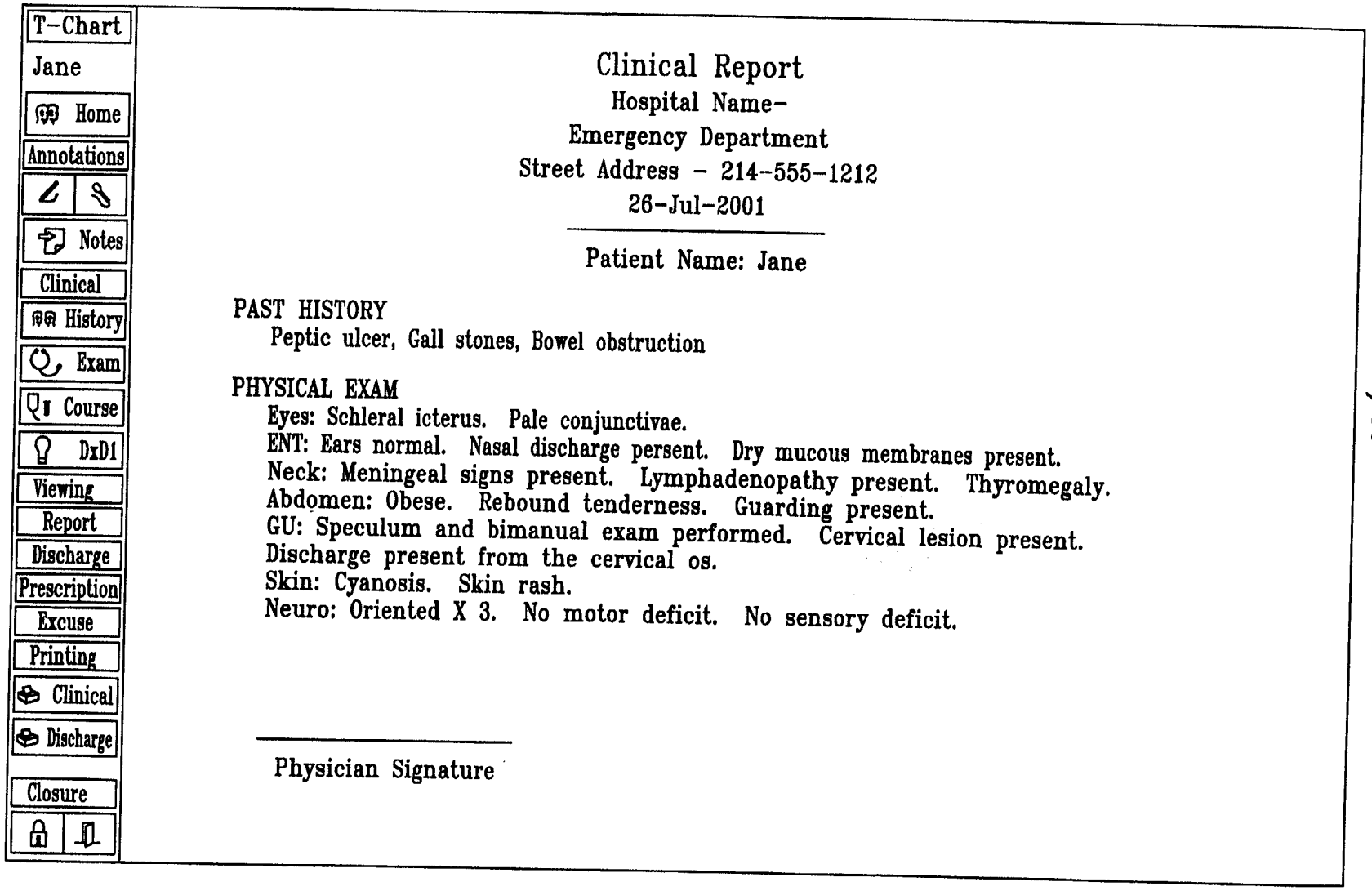
U.S. Serial # 09/927,972

FIG. 31



Clinical Report
Hospital Name-
Emergency Department
Street Address - 214-555-1212
26-Jul-2001

Patient Name: Jane

PAST HISTORY
Peptic ulcer, Gall stones, Bowel obstruction

PHYSICAL EXAM
Eyes: Schleral icterus. Pale conjunctivae.
ENT: Ears normal. Nasal discharge persent. Dry mucous membranes present.
Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.
Abdomen: Obese. Rebound tenderness. Guarding present.
GU: Speculum and bimanual exam performed. Cervical lesion present.
Discharge present from the cervical os.
Skin: Cyanosis. Skin rash.
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

Physician Signature

TSYS 25,410
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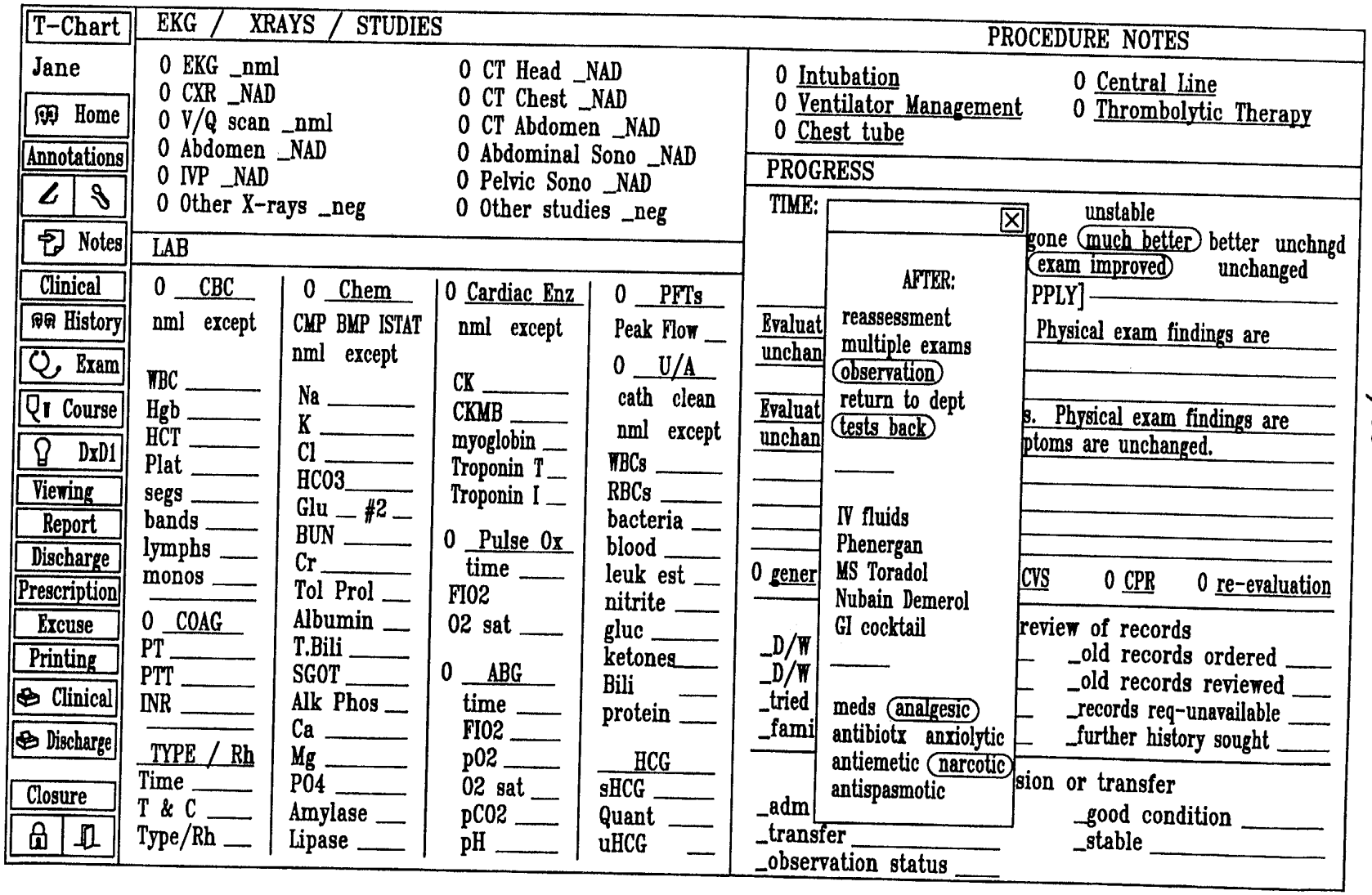
FIG. 32



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U.S. Serial # 09/927,972

FIG. 33

T-Chart

Jane

Home

Annotations

Notes

Clinical History

Exam

Course

DxD1

Viewing

Report

Discharge

Prescription

Excuse

Printing

Clinical

Discharge

Closure

EKG / XRAYS / STUDIES

0 EKG _nml
0 CXR _NAD
0 V/Q scan _nml
0 Abdomen _NAD
0 IVP _NAD
0 Other X-rays _neg

0 CT Head _NAD
0 CT Chest _NAD
0 CT Abdomen _NAD
0 Abdominal Sono _NAD
0 Pelvic Sono _NAD
0 Other studies _neg

LAB

0 CBC
nml except
WBC
Hgb
HCT
Plat
segs
bands
lymphs
monos

0 COAG
PT
PTT
INR

TYPE / Rh
Time
T & C
Type/Rh

0 Chem
CMP BMP ISTAT
nml except
Na
K
Cl
HCO3
Glu #2
BUN
Cr
Tol Prol
Albumin
T.Bili
SGOT
Alk Phos
Ca
Mg
PO4
Amylase
Lipase

0 Cardiac Enz
nml except
CK
CKMB
myoglobin
Troponin T
Troponin I

0 Pulse Ox
time
FIO2
02 sat

0 ABG
time
FIO2
pO2
02 sat
pCO2
pH

0 PFTs
Peak Flow
0 U/A
cath clean
nml except
WBCs
RBCs
bacteria
blood
leuk est
nitrite
gluc
ketones
Bili
protein

HCG
sHCG
Quant
uHCG

PROCEDURE NOTES

0 Intubation
0 Ventilator Management
0 Chest tube
0 Central Line
0 Thrombolytic Therapy

PROGRESS

TIME: _____- now stable unstable
sx's gone much better better unchngd
exam improved unchanged

[APPLY]

Evaluation after reassessment. Physical exam findings are unchanged.

Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged.

Evaluation after observation, results of tests back, analgesic and narcotic. Physical exam findings are improved. Symptoms much better.

0 general course 0 Resp / CVS 0 CPR 0 re-evaluation

consultation / review of records

_D/W Dr. _____ _old records ordered ____
_D/W Dr.(#2) _____ _old records reviewed ____
_tried - can't contact Dr. ____ _records req-unavailable ____
_family consultation _____ _further history sought ____

hospital admission or transfer

_admit _____ _good condition _____
_transfer _____ _stable _____
_observation status _____

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FIG. 34

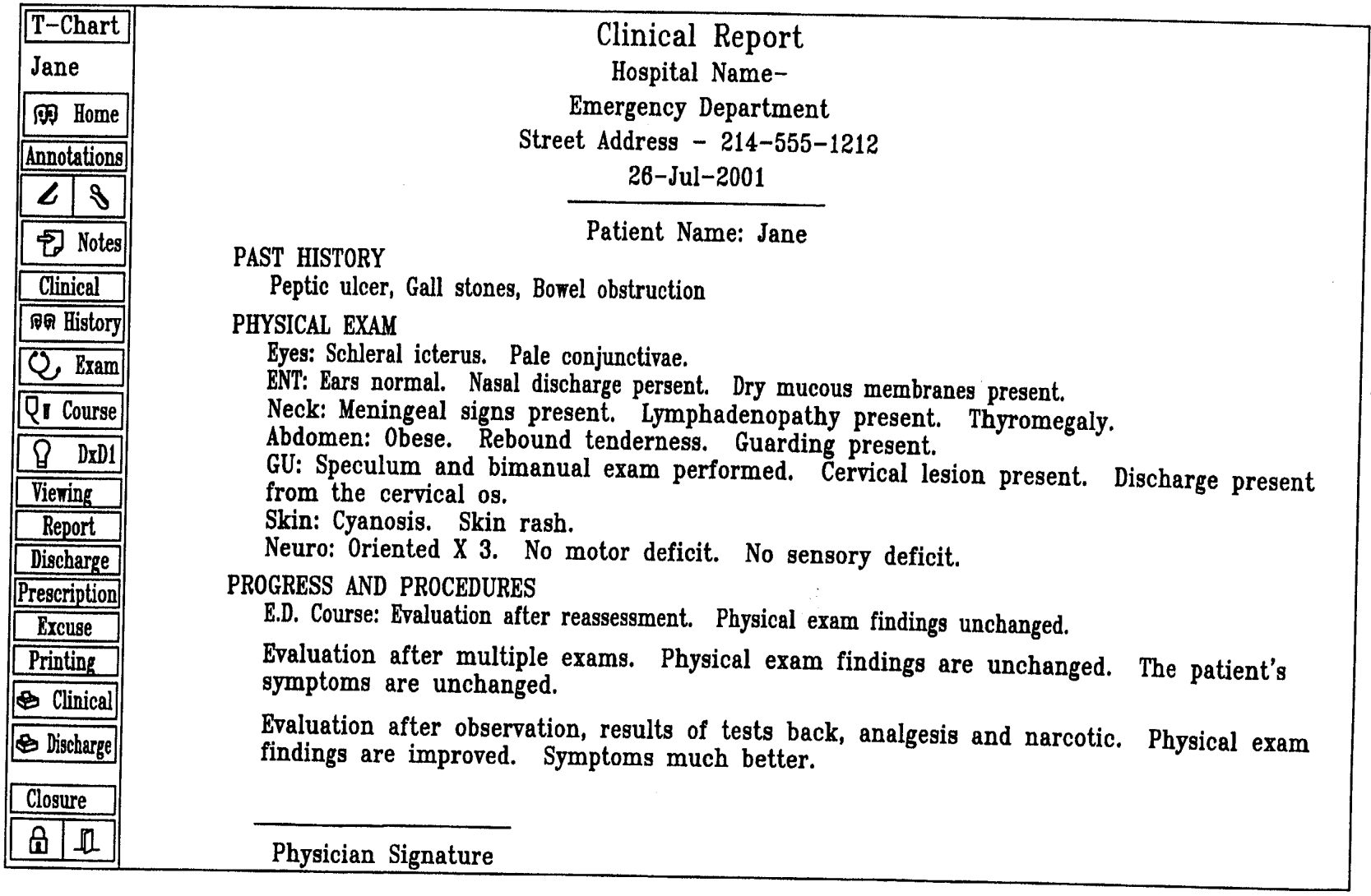


FIG. 35

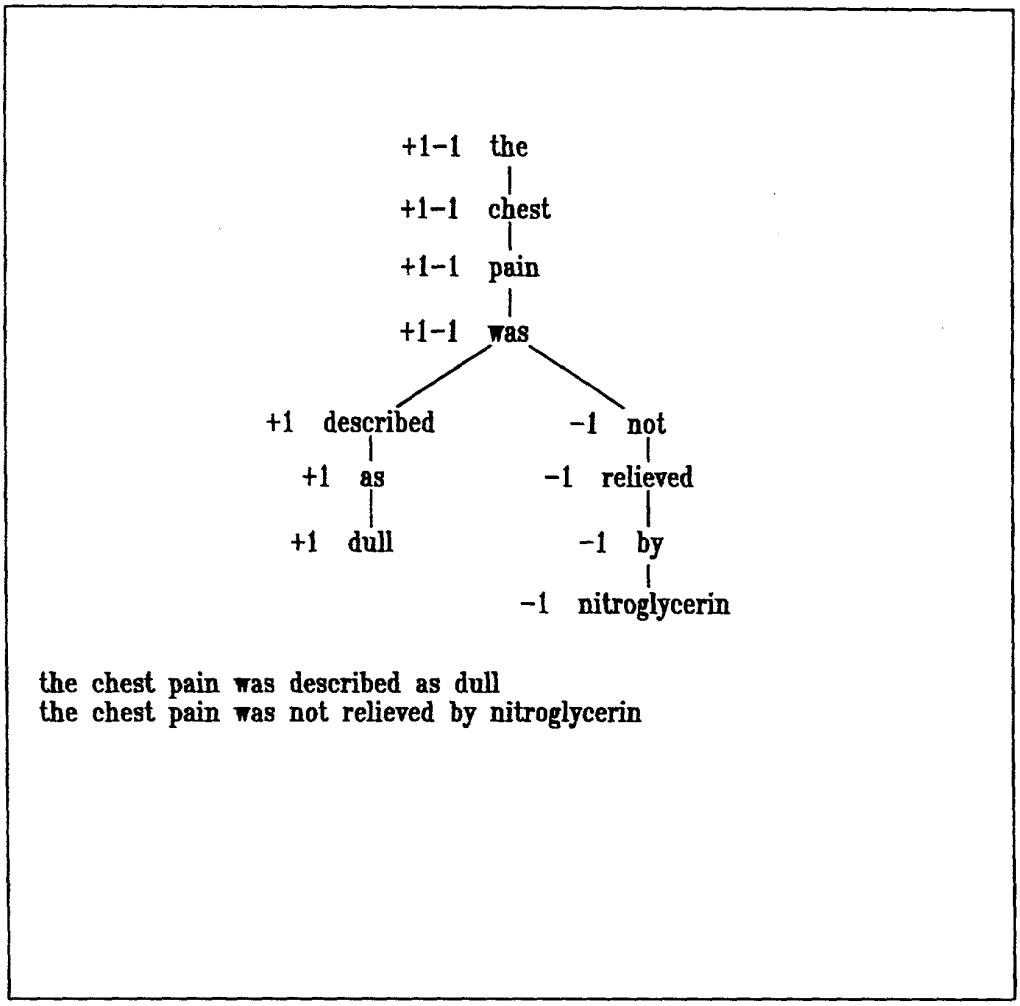
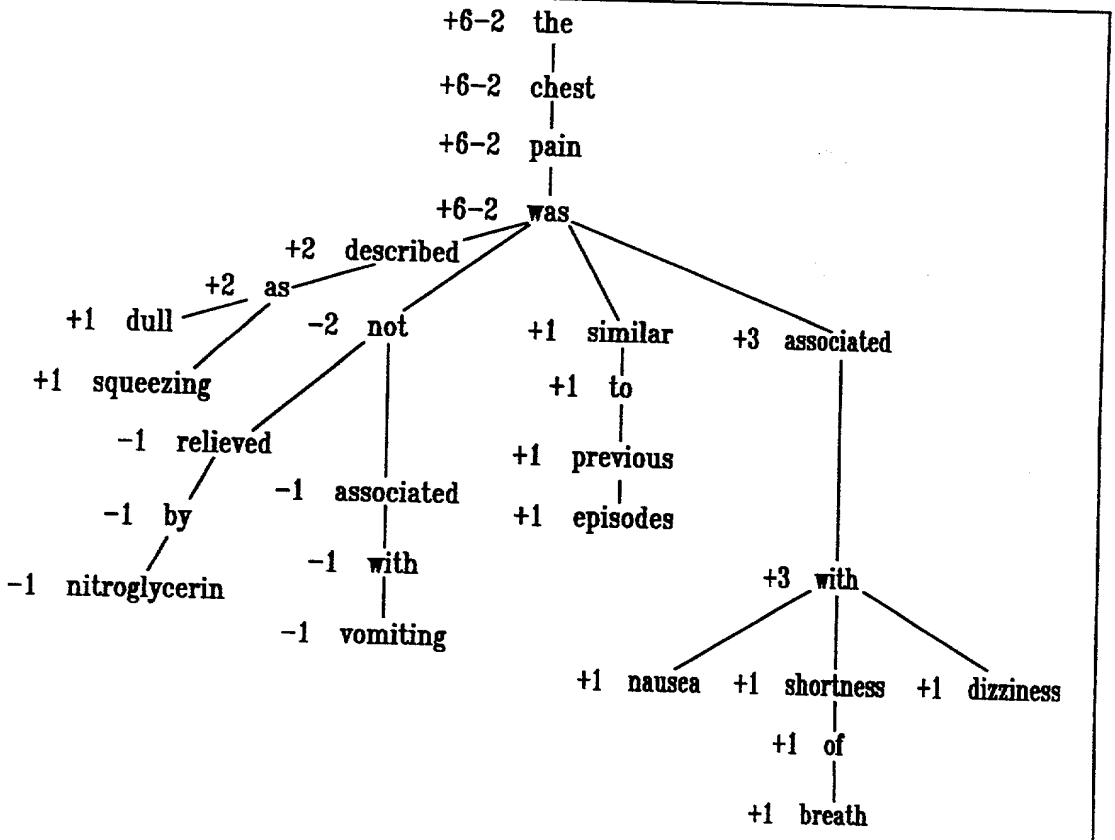

+1-1 the
+1-1 chest
+1-1 pain
+1-1 was
+1 described
+1 as
+1 dull
-1 not
-1 relieved
-1 by
-1 nitroglycerin
the chest pain was described as dull
the chest pain was not relieved by nitroglycerin

FIG. 36



the chest pain was described as dull
the chest pain was not relieved by nitroglycerin
the chest pain was similar to previous episodes
the chest pain was described as squeezing
the chest pain was associated with nausea
the chest pain was not associated with vomiting
the chest pain was associated with shortness of breath
the chest pain was associated with dizziness

FIG. 37